



CancerFit® Exercise Program

WELCOME to CancerFit®! We are excited to have you in this wonderful program!

Fitness Assessment – Your fitness assessment is scheduled for _____

with _____

Comfortable exercise clothes, sturdy shoes and water are recommended for your assessment

By joining the CancerFit® Program you will receive:

- Free access to the Wheat Ridge Recreation Center while you are enrolled in the program.
- Fitness assessments twice during the program: one at the start and one at the end of the 3 months (pre & post assessment)
- Participation in our twice weekly classes specifically for cancer survivors.
- Personalized exercise program based on your assessment results, limitations and goals.
- Weekly consultations with the program coordinator for the duration of the program to discuss issues or concerns and to keep you on track.

The price for this amazing 12 week program is \$220; and for qualifying applicants, full or partial scholarships are available.

Here is a checklist to help get you started:

- _____ Complete all the enclosed paperwork **before your first meeting with the CancerFit® Program Coordinator for your pre-assessment.**
- _____ Please have one of your physicians (oncologist, surgeon, radiation oncologist, etc.) complete the enclosed **Physician’s Approval** form. You may bring it with you the first time you meet your program coordinator or you may have the physician’s office fax it to the phone number on the form (303-231-1306).
- _____ Submit the payment for the program. Please pay at the Front Desk or pay online.
- _____ Bring all completed paperwork to your initial appointment-
 - General health information
 - Health History Questionnaire
 - Completed Physician’s Approval Form
 - PAR-Q+ Questionnaire
 - Quality of Life Survey
 - a current list of medications

We look forward to meeting you and helping you **Get Back to Being You!**

Call Stephen Clyde at 303-231-1306 if you have any questions.



Get Back To Being You!

General Health Information

Name: _____ Age: _____ DOB: _____

Address: _____ Home/Cell Phone: _____

City, State, Zip: _____ Email: _____

Current Employer: _____

Emergency Contact: _____ Phone: _____

Ethnicity (optional): African American Caucasian Asian Pacific Hispanic Native American

How did you hear about the program? _____

Are you involved in a support group? If so, which one? _____

Exercise Information:

Previous Exercise: (Type, frequency, intensity, duration, etc.) _____

Current Exercise: (Type, frequency, intensity, duration, etc.) _____

What are your fitness goals in participating in the program? _____



Get Back To Being You!

What, if any, have been your road blocks to maintaining an exercise program in the past? _____

How would you rate your current level of aerobic fitness? (Please circle one)

Very Low	Low	Average	High	Very High
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How would you rate your current level of knowledge/ experience with the following fitness equipment/modalities? (1=never done it-10=very experienced)

Activity	Experience
Walking/running on the treadmill	
Stationary/recumbent bike	
Elliptical machines	
Dumbbells	
Elastic resistance bands/tubes	
Weight machines	
BOSUs/medicine balls/yoga balls	

Please list any exercise equipment you have available to you at home: _____



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-Continued-

Please list any exercise restrictions you have recently been given by a physician. (Please give the reason for restriction as well as the date it was given). _____

Cancer History:

Type of cancer(s), location and date(s) of diagnosis including cancer stage: _____

How did you learn of your diagnosis? (What made you go in for a doctor's visit?) _____

Please describe any cancer-related surgeries you've had (type, date, recovery, lymph node dissection, reconstruction): _____

Please describe any side effects of your surgery: _____



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-Continued-

Chemotherapy/radiation/hormone therapy/biotherapy treatment: Please describe your treatment schedule (type of drugs, how long, start/end dates, what method, how frequently, etc.): _____

Do you currently have a chemotherapy port in place? Y / N

Please describe any side effects of your treatment: _____

Are you currently using any alternative/complimentary therapy: (supplements, herbs, acupuncture, aromatherapy etc.): Y / N

If yes, please describe what type: _____

Do you have any physical limitations you feel we need to know about that may affect your exercise prescription? _____

Do you use medications/therapies to manage symptoms related to your cancer/treatment?: _____



Informed Consent

In order to assess cardiovascular function, strength and flexibility before and after an exercise intervention, the undersigned hereby voluntarily consents to engage in sub-maximal graded exercise tests, flexibility and strength testing.

Explanation of tests:

The sub-maximal graded exercise test will test the capacity and function of the cardiovascular system. Depending on the protocol used, the test is stopped when a certain time is reached, or the participant reached a pre-determined heart rate. The test may be stopped at any time because of fatigue or discomfort. The strength tests consist of doing a number of repetitions to volitional fatigue or until a specific time has been reached. These tests may be adjusted according to the needs of the individual.

Risks and discomforts:

During the graded exercise test, certain changes may occur. These changes include: abnormal blood pressure response, fainting, irregularities in heart rate and heart attack. The risks during the strength testing consist of muscle strain or injury or the irritation of surgery-affected limbs, which could lead to lymphedema.

Expected benefits from testing:

These tests allow us to assess your physical working capacity and strength and to appraise your physical fitness status clinically. The results are used to prescribe a safe, sound exercise program for you and to monitor changes as you continue to exercise. Records are kept strictly confidential unless you consent to release this information.

Inquiries:

Questions about the procedures used in these tests are encouraged. If you have any questions or need any additional information, please ask us to explain further.

Freedom of consent:

Your permission to perform this test is strictly voluntary. You are free to deny consent if you so desire.

I have read this form carefully and I fully understand the test procedures. I consent to participate in this test.

Signature of participant

Date

Witness

Date

Ferrans and Powers
QUALITY OF LIFE INDEX[®]
CANCER VERSION - III

PART I. For each of the following, please choose the answer that best describes how satisfied you are with that area of your life. Please mark your answer by circling the number. There are no right or wrong answers.

HOW SATISFIED ARE YOU WITH:	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied
1. Your health?	1	2	3	4	5	6
2. Your health care?	1	2	3	4	5	6
3. The amount of pain that you have?	1	2	3	4	5	6
4. The amount of energy you have for everyday activities?	1	2	3	4	5	6
5. Your ability to take care of yourself without help?	1	2	3	4	5	6
6. The amount of control you have over your life?	1	2	3	4	5	6
7. Your chances of living as long as you would like?	1	2	3	4	5	6
8. Your family's health?	1	2	3	4	5	6
9. Your children?	1	2	3	4	5	6
10. Your family's happiness?	1	2	3	4	5	6
11. Your sex life?	1	2	3	4	5	6
12. Your spouse, lover, or partner?	1	2	3	4	5	6
13. Your friends?	1	2	3	4	5	6
14. The emotional support you get from your family?	1	2	3	4	5	6
15. The emotional support you get from people other than your family?	1	2	3	4	5	6

(Please Go To Next Page)

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HOW SATISFIED ARE YOU WITH:

	Very Dissatisfied	Moderately Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Moderately Satisfied	Very Satisfied
16. Your ability to take care of family responsibilities?	1	2	3	4	5	6
17. How useful you are to others?	1	2	3	4	5	6
18. The amount of worries in your life?	1	2	3	4	5	6
19. Your neighborhood?	1	2	3	4	5	6
20. Your home, apartment, or place where you live?	1	2	3	4	5	6
21. Your job (if employed)?	1	2	3	4	5	6
22. Not having a job (if unemployed, retired, or disabled)?	1	2	3	4	5	6
23. Your education?	1	2	3	4	5	6
24. How well you can take care of your financial needs?	1	2	3	4	5	6
25. The things you do for fun?	1	2	3	4	5	6
26. Your chances for a happy future?	1	2	3	4	5	6
27. Your peace of mind?	1	2	3	4	5	6
28. Your faith in God?	1	2	3	4	5	6
29. Your achievement of personal goals?	1	2	3	4	5	6
30. Your happiness in general?	1	2	3	4	5	6
31. Your life in general?	1	2	3	4	5	6
32. Your personal appearance?	1	2	3	4	5	6
33. Yourself in general?	1	2	3	4	5	6

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PART 2. For each of the following, please choose the answer that best describes how *important* that area of your life is to you. Please mark your answer by circling the number. There are no right or wrong answers.

HOW IMPORTANT TO YOU IS:	Very Unimportant	Moderately Unimportant	Slightly Unimportant	Slightly Important	Moderately Important	Very Important
1. Your health?	1	2	3	4	5	6
2. Your health care?	1	2	3	4	5	6
3. Having no pain?	1	2	3	4	5	6
4. Having enough energy for everyday activities?	1	2	3	4	5	6
5. Taking care of yourself without help?	1	2	3	4	5	6
6. Having control over your life?	1	2	3	4	5	6
7. Living as long as you would like?	1	2	3	4	5	6
8. Your family's health?	1	2	3	4	5	6
9. Your children?	1	2	3	4	5	6
10. Your family's happiness?	1	2	3	4	5	6
11. Your sex life?	1	2	3	4	5	6
12. Your spouse, lover, or partner?	1	2	3	4	5	6
13. Your friends?	1	2	3	4	5	6
14. The emotional support you get from your family?	1	2	3	4	5	6
15. The emotional support you get from people other than your family?	1	2	3	4	5	6

(Please Go To Next Page)

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HOW IMPORTANT TO YOU IS:

	Very Unimportant	Moderately Unimportant	Slightly Unimportant	Slightly Important	Moderately Important	Very Important
16. Taking care of family responsibilities?	1	2	3	4	5	6
17. Being useful to others?	1	2	3	4	5	6
18. Having no worries?	1	2	3	4	5	6
19. Your neighborhood?	1	2	3	4	5	6
20. Your home, apartment, or place where you live?	1	2	3	4	5	6
21. Your job (if employed)?	1	2	3	4	5	6
22. Having a job (if unemployed, retired, or disabled)?	1	2	3	4	5	6
23. Your education?	1	2	3	4	5	6
24. Being able to take care of your financial needs?	1	2	3	4	5	6
25. Doing things for fun?	1	2	3	4	5	6
26. Having a happy future?	1	2	3	4	5	6
27. Peace of mind?	1	2	3	4	5	6
28. Your faith in God?	1	2	3	4	5	6
29. Achieving your personal goals?	1	2	3	4	5	6
30. Your happiness in general?	1	2	3	4	5	6
31. Being satisfied with life?	1	2	3	4	5	6
32. Your personal appearance?	1	2	3	4	5	6
33. Are you to yourself?	1	2	3	4	5	6

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PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

Regular physical activity is fun and healthy, and more people should become more physically active every day of the week. Being more physically active is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

SECTION 1 - GENERAL HEALTH

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition OR high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
3) Do you lose balance because of dizziness OR have you lost consciousness in the last 12 months? Please answer NO if your dizziness was associated with over-breathing (including during vigorous exercise).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition?	<input type="checkbox"/>	<input type="checkbox"/>
6) Do you have a bone or joint problem that could be made worse by becoming more physically active? Please answer NO if you had a joint problem in the past, but it <u>does not limit your current ability</u> to be physically active. For example, knee, ankle, shoulder or other.	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

 **If you answered NO to all of the questions above, you are cleared for physical activity. Go to Section 3 to sign the form. You do not need to complete Section 2.**

-  Start becoming much more physically active – start slowly and build up gradually.
-  Follow Canada's Physical Activity Guidelines for your age (www.csep.ca/guidelines).
-  You may take part in a health and fitness appraisal.
-  If you have any further questions, contact a qualified exercise professional such as a CSEP Certified Exercise Physiologist® (CSEP-CEP) or a CSEP Certified Personal Trainer® (CSEP-CPT).
-  If you are over the age of 45 yr and **NOT** accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

 **If you answered YES to one or more of the questions above, please GO TO SECTION 2.**

 **Delay becoming more active if:**

-  You are not feeling well because of a temporary illness such as a cold or fever - wait until you feel better
-  You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ before becoming more physically active OR
-  Your health changes - please answer the questions on Section 2 of this document and/or talk to your doctor or qualified exercise professional (CSEP-CEP or CSEP-CPT) before continuing with any physical activity programme.

PAR-Q+

SECTION 2 - CHRONIC MEDICAL CONDITIONS

1. Do you have Arthritis, Osteoporosis, or Back Problems?

YES If yes, answer questions 1a-1c **NO** If no, go to question 2

1a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) **YES** **NO**

1b. Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)? **YES** **NO**

1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months? **YES** **NO**

2. Do you have Cancer of any kind?

YES If yes, answer questions 2a-2b **NO** If no, go to question 3

2a. Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and neck? **YES** **NO**

2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)? **YES** **NO**

3. Do you have Heart Disease or Cardiovascular Disease? *This includes Coronary Artery Disease, High Blood Pressure, Heart Failure, Diagnosed Abnormality of Heart Rhythm*

YES If yes, answer questions 3a-3e **NO** If no, go to question 4

3a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) **YES** **NO**

3b. Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction) **YES** **NO**

3c. Do you have chronic heart failure? **YES** **NO**

3d. Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure) **YES** **NO**

3e. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months? **YES** **NO**

4. Do you have any Metabolic Conditions? *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes*

YES If yes, answer questions 4a-4c **NO** If no, go to question 5

4a. Is your blood sugar often above 13.0 mmol/L? (Answer **YES** if you are not sure) **YES** **NO**

4b. Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, and the sensation in your toes and feet? **YES** **NO**

4c. Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)? **YES** **NO**

5. Do you have any Mental Health Problems or Learning Difficulties? *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome*

YES If yes, answer questions 5a-5b **NO** If no, go to question 6

5a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) **YES** **NO**

5b. Do you also have back problems affecting nerves or muscles? **YES** **NO**

PAR-Q+

6. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

YES If yes, answer questions 6a-6d **NO** If no, go to question 7

- 6a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) **YES** **NO**
-
- 6b. Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy? **YES** **NO**
-
- 6c. If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week? **YES** **NO**
-
- 6d. Has your doctor ever said you have high blood pressure in the blood vessels of your lungs? **YES** **NO**

7. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

YES If yes, answer questions 7a-7c **NO** If no, go to question 8

- 7a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) **YES** **NO**
-
- 7b. Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting? **YES** **NO**
-
- 7c. Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)? **YES** **NO**

8. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

YES If yes, answer questions 8a-c **NO** If no, go to question 9

- 8a. Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments) **YES** **NO**
-
- 8b. Do you have any impairment in walking or mobility? **YES** **NO**
-
- 8c. Have you experienced a stroke or impairment in nerves or muscles in the past 6 months? **YES** **NO**

9. Do you have any other medical condition not listed above or do you live with two chronic conditions?

YES If yes, answer questions 9a-c **NO** If no, read the advice on page 4

- 9a. Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months? **YES** **NO**
-
- 9b. Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)? **YES** **NO**
-
- 9c. Do you currently live with two chronic conditions? **YES** **NO**

Please proceed to Page 4 for recommendations for your current medical condition and sign this document.

PAR-Q+

If you answered **NO** to all of the follow-up questions about your medical condition, you are ready to become more physically active:

-  It is advised that you consult a qualified exercise professional (e.g., a CSEP-CEP or CSEP-CPT) to help you develop a safe and effective physical activity plan to meet your health needs.
-  You are encouraged to start slowly and build up gradually - 20-60 min of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
-  As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
-  If you are over the age of 45 yr and **NOT** accustomed to regular vigorous physical activity, please consult a qualified exercise professional (CSEP-CEP) before engaging in maximal effort exercise.

If you answered **YES** to one or more of the follow-up questions about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. It is recommended strongly that you complete the specially designed online screening and exercise recommendations program (i.e., the ePARmed-X+; www.eparmedx.com) and/or visit a qualified exercise professional (CSEP-CEP) for further information.

Delay becoming more active if:

-  You are not feeling well because of a temporary illness such as a cold or fever - wait until you feel better
-  You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ before becoming more physically active OR
-  Your health changes - please talk to your doctor or qualified exercise professional (CSEP-CEP) before continuing with any physical activity programme.

SECTION 3 - DECLARATION

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The PAR-Q+ Collaboration, the Canadian Society for Exercise Physiology, and their agents assume no liability for persons who undertake physical activity. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.
- Please read and sign the declaration below:

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that they maintain the privacy of the information and do not misuse or wrongfully disclose such information.

NAME _____

DATE _____

SIGNATURE _____

WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com
Canadian Society for Exercise Physiology
www.csep.ca

Citation for PAR-Q+

Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

Key References

1. Jamnik VJ, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation; background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(S1):S266-s298, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or BC Ministry of Health Services.



Get Back To Being You!

Wheat Ridge Recreation Center Cancer Fit Godin Leisure-Time Exercise Questionnaire

Name: _____ Date: _____

1. During a typical **7-Day period** (a week), how many times on the average do you do the following kinds of exercise for **more than 15 minutes** during your free time (write in on each line the appropriate number).

Times Per Week

a) STRENUOUS EXERCISE (HEART BEATS RAPIDLY) _____
(e.g., running, jogging, hockey, football, soccer, squash, basketball, cross country skiing, Judo, roller skating, vigorous swimming, vigorous long distance bicycling)

b) MODERATE EXERCISE (NOT EXHAUSTING) _____
(e.g. fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular & folk dancing)

c) MILD EXERCISE (MINIMAL EFFORT) _____
(e.g. yoga, archery, fishing from river bank, bowling, horseshoes, golf, snow-mobiling, easy walking)

2. During a typical **7-Day period** (a week), in your leisure time, how often do you engage in any regular activity **long enough to work up a sweat** (heart beats rapidly)? Check one:

1. Often

2. Sometimes

3. Never/Rarely



Get Back To Being You!

Wheat Ridge Recreation Center
4005 Kipling St. Wheat Ridge, CO, 80033

Dear Dr. _____

The CancerFit® exercise program is available to all cancer survivors. This exercise program is an affordable, professionally directed exercise program for cancer survivors offered in a community setting. Your patient, _____ has expressed an interest in participating in this program. Based on past and/or current medical diagnoses and treatments, we are requesting your approval and recommendations for their participation in an exercise program.

The 12 week exercise program offers pre- and post- fitness testing, to include weight, blood pressure, resting heart rate, percent body fat, circumference, strength, flexibility and aerobic capacity estimation. Participants receive an exercise prescription based on their results, needs, limitations and goals. Participants also work closely with their CancerFit® Program Coordinator during the 12 week program to make sure that their exercise routine is individually appropriate and effective.

Please complete the medical approval/recommendation form. You may return it to your patient, mail it to CancerFit® (Stephen Clyde, 4005 Kipling St. Wheat Ridge, CO 80033) or fax it to **Attention:** (CancerFit®, Stephen Clyde, 303-231-1306). If you would like any additional information about this program, please call me at 303-231-1306.

Thank you for your cooperation.

Sincerely,

Stephen Clyde
Fitness Coordinator



Physician Approval/Recommendations

Patient Name: _____ Age: _____

Diagnosis: _____

Medications: _____

Please list **recommendations and/or limitations** this patient might have during exercise using treadmills, bikes, circuit equipment, free weights and exercise classes.

Is this patient cleared for participation in the CancerFit® Program? (Circle one) YES NO

Signature of Physician

Date

Name of Physician

Office Phone

Street Address

City, State, Zip

What is the best method to communicate with you?

Preparing for your Assessment:

During your fitness assessment you will meet privately with your assigned CancerFit® Program Coordinator, to evaluate your current level of functional fitness. The assessment will take approximately one hour and includes the following:

- Review of previous medical history
- Goal setting
- Resting Heart Rate/Blood Pressures
- Circumference measurements
- Body Composition
- Balance & agility
- Cardiovascular endurance
- Muscular strength/endurance
- Flexibility

This is not a pass/fail endeavor; the assessments are designed to determine where you are, *at this time*, with regard to your functional fitness. This will enable us to establish a baseline fitness level, and ensure accuracy and individuality in the development of your exercise program. When the assessments have been completed, your program coordinator will discuss the overall results with you and a copy will be provided for you to keep with your records.

Pre-Test Guidelines:

These guidelines will ensure your assessment is conducted safely and comfortably, and the results are as accurate as possible.

- Get a good night's sleep
- Drink plenty of fluids in the 24 hours leading up to your assessment
- Arrive 5-10 minutes early...being late can bump up your heart rate
- Avoid strenuous exercise 24 hours prior to the assessment and do not engage in any exercise the day of.
- In the two hours before completing the tests do not consume a heavy meal; however, you are strongly advised to have eaten some food in the four hours preceding testing.
- Caffeine products (such as coffee, cola or tea) should be avoided on the day of testing.
- Alcoholic beverages and tobacco products should be avoided 24 hours prior to testing.
- Wear loose fitting, comfortable exercise clothing (sneakers, shorts, t-shirt etc.)
- Bring water
- Bring a CURRENT list of medications with you

Please note that all tests are voluntary and can be stopped at any time. If you feel any discomfort – physically or psychologically – inform the program coordinator immediately.



Get Back To Being You!

Health History Questionnaire

Name: _____

Date: _____

<u>Past History</u>	<u>Family History</u>	<u>Present Symptoms/Conditions</u>
<i>Check if you've had...</i>	<i>(Including parents, grandparents, siblings)...</i>	<i>Do you experience...</i>
<input type="checkbox"/> Rheumatic Fever	<i>Have any relatives had...</i>	<input type="checkbox"/> Chest Pains
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Heart Attacks	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Disease of the arteries	<input type="checkbox"/> Heart Operations	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Lymphedema
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Cancer	<input type="checkbox"/> Other Major Illness	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Lymphedema		<input type="checkbox"/> Swollen Legs
<input type="checkbox"/> Lung Disease		<input type="checkbox"/> Other
<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Varicose Veins		
<input type="checkbox"/> Injuries to Back		
<input type="checkbox"/> Injuries to Knees, etc.		
<input type="checkbox"/> Surgery		
<input type="checkbox"/> Other		

Explain each checked item: _____

HOSPITALIZATIONS/SURGERIES	
List all reasons you were hospitalized (excluding your cancer diagnosis/treatment)	Year
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

ALL ALLERGIES REACTION (MEDICATIONS/FOODS/ETC)
1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS	
(List all medication you take on a regular basis including over the counter medications)	
1. _____	Reason: _____
2. _____	Reason: _____
3. _____	Reason: _____
4. _____	Reason: _____
5. _____	Reason: _____



Get Back To Being You!

Please circle any symptoms you are currently experiencing or mark the circle if you are not

Category	Symptoms	No Symptoms
General	Appetite change Fatigue Fever Sweats Weight loss Weight gain Weakness	<input type="radio"/>
Skin	Itching Rash Mole change	<input type="radio"/>
Eyes	Vision change Cataracts Glaucoma	<input type="radio"/>
Ears/Nose/Mouth	Dizziness Ringing in ears Sore throat Runny nose Nosebleeds	<input type="radio"/>
Lungs	Cough Shortness of breath Chest pain Coughing up blood Wheezing	<input type="radio"/>
Heart	Chest pain Palpitations Fainting	<input type="radio"/>
GI	Abdominal pain Nausea Vomiting Diarrhea Constipation Jaundice Blood in stool Difficulty swallowing	<input type="radio"/>
Urinary	Painful urination Increased frequency Urgency Blood in urine Kidney stones	<input type="radio"/>
Musculoskeletal	Arthritis Stiffness Swelling Weakness Backache	<input type="radio"/>
Nervous System	Headache Seizure Dizziness Memory loss Numbness/tingling Anxiety Depression Personality change	<input type="radio"/>
Reproductive	(M) Testicular pain (M) Swelling (W) Pelvic pain (W) Abnormal bleeding	<input type="radio"/>
Hematologic	Bruising Bleeding Recurring infections	<input type="radio"/>
Lymph Nodes	Enlargement Tenderness	<input type="radio"/>

experiencing any of these symptoms.

****If you need additional space, please use another sheet of paper****



Get Back To Being You!

Intake Form

Name: _____

Date: _____ DOB: _____

How did you heard about the program? _____

Phone number: _____ Email: _____

Type of cancer: _____ Date of diagnosis: _____

Chemotherapy/radiation: _____

Surgery/reconstruction: _____

Lymph nodes removed? Y/N How many and what side? _____

Side effects: _____

Which program/class time are you interested in? _____

Notes: _____

Dr./Oncologist information: _____

Cancer Fit Exercise Program

Lymphedema Informative Sheet



What is the lymph system?

Our bodies have a network of lymph vessels and nodes that drain and carry lymph fluid much the same way that blood vessels move through the body. Lymph fluid contains proteins, salts and water, as well as white blood cells, which help us fight infections and other diseases. Within the lymph vessels, there are valves which work with muscles to help move the fluid through the body. Lymph nodes serve as filters for harmful substances and help us fight infection.

What is lymphedema?

Lymphedema can happen as a result of cancer, cancer treatments, or anything that changes a normal, healthy lymph system. Lymphedema is the swelling of arms, legs, or trunk that occurs from the buildup of lymph fluid. Lymphedema stops lymph fluid from flowing freely in your body and often causes swelling in your body that you can see and feel.

What causes lymphedema?

Any change in the structure of the lymph system puts a person at risk for lymphedema. Sometimes radiation damages lymph nodes and sometimes during surgery for cancer, the doctor will remove a few or several lymph nodes to see if cancer is present or has spread. Taking out lymph nodes and vessels changes the way the lymph fluid flows in that part of the body, making it harder for the lymph fluid in the arms and legs to circulate to other parts of the body.

Who is at risk for lymphedema?

Any condition or procedure that damages your lymph nodes or lymph vessels can cause lymphedema. Causes can include surgery, biopsy, radiation treatment, a growing cancer tumor, infections, and injuries. Lymphedema can become a problem after surgery or radiation treatment of any type of cancer, but is most often linked to breast cancer, prostate cancer, ovarian cancer, lymphoma, and melanoma.

What are some symptoms of lymphedema?

- Noticeable swelling of the arms, legs or trunk
- Feeling of fullness or discomfort in arm, leg, or genitals
- Not being as flexible in the hand, wrist, or ankle
- Trouble or difficulty fitting into your clothes
- Sudden tightness of rings, watches, or bracelets
- Infections that won't go away or keep coming back
- Feeling of tightness in the skin

When could lymphedema happen?

Lymphedema can occur during treatment or years after your treatment ends. The more common form of lymphedema develops slowly over time. The swelling can range from mild to severe. Whether or not you will get

lymphedema or when, really depends on the type of cancer you had, the type of treatment you received, and how your body handled it all.

What can you do to minimize your risks for lymphedema?

- Watch for even slight increase in size or swelling of the arm, hand, fingers, chest wall, trunk or legs.
- Avoid having injections, finger sticks, or blood draws from the arm that might be at risk for lymphedema.
- Do not have blood pressure checked from the at-risk arm.
- Keep the skin of at-risk arms or legs very clean and healthy.
- Make sure the at-risk arm or leg gets proper circulation.
- Avoid heavy lifting with the affected arm.
- Avoid vigorous, repetitive movements against strenuous resistance with the at-risk arm or leg.
- Avoid extreme temperature changes on the at-risk arm or leg.
- Protect affected limbs from the sun at all times.
- Minimize chances of any injury: bruises, cuts, sunburn or other burns, sports injuries, insect bites, or scratches to the affected arm or leg.
- Take special precautions when traveling by air.
- Maintain a healthy weight with a well-balanced diet and plenty of fluids.
- Establish a safe exercise program.

In general, maintaining a healthy lifestyle which includes regular moderate exercise, good nutritional habits, stress management, controlling body weight and taking certain precautions will help to decrease the risk of lymphedema. If any activity hurts or is irritating, discontinue that exercise and seek advice from the Cancer Fit Personal Trainer or your physician.