LIVESTRONG® AT THE YMCA

REGISTRATION FORM

Name: _____ **DOB:** _____

Phone (Primary): _____ **Age:** _____

Cell ☐ **Home** ☐ **Work** ☐ (Check One) **Phone (Secondary):** _____

Email: _____ **Cell** ☐ **Home** ☐ **Work** ☐ (Check One)

Date of Diagnosis: _____ **Support Name:** _____

Date of Re-Occurrence: _____ **Relationship:** _____

Support Contact: _____

CANCER TYPE (Check as appropriate)

- ☐ Bladder
- ☐ Bone
- ☐ Brain/Tumor
- ☐ Breast
- ☐ Cervical
- ☐ Colon/Rectal
- ☐ Endometrial
- ☐ Esophageal
- ☐ Gynecological
- ☐ Head and Neck
- ☐ Hodgkin's Disease
- ☐ Kidney
- ☐ Leukemia
- ☐ Liver
- ☐ Lung
- ☐ Lymphoma
- ☐ Melanoma
- ☐ Myeloma
- ☐ Non-Hodgkin's Lymphoma
- ☐ Oral
- ☐ Ovarian
- ☐ Pancreatic
- ☐ Prostate
- ☐ Skin (Non-Melanoma)
- ☐ Stomach
- ☐ Testicular
- ☐ Thyroid
- ☐ Uterine
- ☐ Other: _____

TREATMENT TYPE (Check those that apply)

- ☐ **Chemotherapy** **Last Tx Date:** _____
- ☐ **Surgery** **Most Recent Surgery Date:** _____
- ☐ **Radiation** **Last Tx Date:** _____
- ☐ **Oral Medication** **Currently Taking: YES** ☐ **NO** ☐ (Check One)

Other Health Problems: Additional Notes:

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Asthma
- ☐ Neuropathy

Specify where: _____

Level of Exercise:

- ☐ Light
- ☐ Moderate
- ☐ Vigorous

Currently Working:

- ☐ Yes
- ☐ No
- ☐ Part-Time
- ☐ Retired

Additional Comments:

How did you hear about the program? _____

CLASS OPTIONS

Time of Day Availability: _____

Day of Week Availability: _____

Class Interested In: _____

YMCA Location Closest to You: _____

Additional Comments: