UNC WELLNESS CENTERS MEADOWMONT

The LiveFit Cancer Exercise Program

In order to participate in the LiveFit Cancer Exercise Program at the UNC Wellness Centers, the applicant must read and understand the Code of Conduct Policy and complete all of the following before participating:

- Waiver and Release of Liability from a physician
- Information Form with Medical History Questionnaire
- Physical Activity Readiness Questionnaire (PAR-Q)
- Fatigue Questionnaire
- Quality of Life Questionnaire

Applicants will not be allowed to participate in the programs if the documents listed above have not been completed and signed. Participants will be contacted after the LiveFit Application has been reviewed by the staff. **Pre-registration is required, as class space is limited**.

Participant Responsibilities

- In order for an applicant to participate in the LiveFit Cancer Exercise Program at the UNC Wellness Centers, he/she must intend to participate in all of the sessions, and also get a health screening during the first week and last week of the program.
- Exercise Sessions are held at the UNC Wellness Centers from 5-6pm on Tuesdays and Thursdays throughout the duration of the 10 weeks.
- Health Screening sessions (at the beginning and end of the program) will take approximately 45 minutes, are scheduled separately with a staff member, and are held when the participant, staff member, and the testing room are all available.

Code of Conduct Policy

Participants of the LiveFit Program at the UNC Wellness Centers are expected to behave in a manner which does not disrupt the class. Participants are expected to:

- Be courteous to the group leader and to fellow classmates
- Arrive on time and report directly to the assigned area
- Be respectful of the equipment, supplies, and facility
- Follow directions provided by the group leader
- Stay with the group

If the participant needs to dismiss themselves from the program due to medical concerns, the participant may do so at any time after notifying the appropriate program administrator.

The UNC Wellness Centers reserves the right to dismiss a participant whose behavior endangers the safety of himself/herself or others.

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The LiveFit Cancer Exercise Program Release of Liability

Name: _____
First Middle Initial Last

By signing this waiver, I accept responsibility for the inherent hazards of my voluntary participation in the LiveFit Cancer Exercise program at the UNC Wellness Centers.

I understand and am aware that strength training, flexibility, and aerobic exercise, including the use of equipment, are potentially hazardous activities. I also understand that fitness activities involve a risk of injury and that I am voluntarily participating in these activities using equipment and machinery with knowledge of the risks involved. I hereby agree to expressly assume and accept any and all risks of injury resulting from use of equipment and/or from fitness activities.

I will not attend the LiveFit Cancer Exercise program if I have knowledge of any treatment complications or infection. If I display any of the above while in the care of the UNC Wellness Centers staff, I understand I am expected to remove myself from the program. Under no circumstances will the staff administer drugs to me.

I do understand that space must be reserved for my participation in the LiveFit Cancer Exercise program at the UNC Wellness Centers.

I have read and understand the code of conduct policy.

In consideration of participating in the activities and programs of the UNC Wellness Centers and to use its facilities, I agree to assume all risks of injury and will hold harmless from any and all liability, causes of actions, claims, and demands of every kind and nature whatsoever, which I now have or which may arise from or in connection with any participation in activities arranged by the UNC Wellness Centers staff and its employees. These terms will serve as a release and assumption of risk for my heirs, executors, and administrators for all members of my family.

I have read and understand all terms to the agreement and conditions stated above.

_____ _____
Print Name Date

_____
Signature

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The LiveFit Cancer Exercise Program Personal Information Form

Name: _____
First Middle Initial Last Nickname

Birthdate: ___/____/_____ Gender: _____ Height: _____ Weight: _____

Home Phone Number: _____ Work Phone Number: _____

Mobile Phone Number: _____ E-mail: _____

Weight History
Today's weight: _____ Desirable weight range: _____

Exercise History
How many days per week do you usually exercise? (Circle one of the following)

0 1 2 3 4 5 6 7

How long do you usually exercise each day? (Circle one of the following)

0-15 minutes 15-30 minutes 30-45 minutes >45 minutes

If you currently exercise, list what you do on a regular basis (i.e. walking, hiking, aerobics)

_____

_____

What are your exercise restrictions? (please describe)

_____

_____

On a scale of 1-10 (10 being the highest level), how severe is your overall fatigue when you exercise?

On the day of exercise/during exercise: 1 2 3 4 5 6 7 8 9 10

On the day AFTER exercise: 1 2 3 4 5 6 7 8 9 10

Medical History (complete what is known)

Cancer Diagnosis:_____ Grade:_____ Date Diagnosed: _____

Types of Cancer Treatments (list all with dates): _____

_____

_____

Are you experiencing Range of Motion difficulties? _____
If yes, which areas are affected? _____

Are you currently experiencing lymphedema? _____
If yes, which areas are affected? _____
What is your current lymphedema treatment? _____

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Typical Blood Pressure:_____ Last Date Tested:_____

Total cholesterol: _____ HDL:_____ LDL:_____ TG:_____ Date Tested: _____

Have you ever had your blood sugar checked? Yes _____ No _____
What were the results? _____ Date of test:_____

Are you currently following a specialized diet? (e.g. low-sodium, low-fat)? Yes _____ No _____
If so, what type of diet? _____

_____

Have you ever met with a registered dietitian? Yes _____ No _____
Are you interested in meeting with one? Yes _____ No _____

How much water do you drink per day? _____ glasses (8 ounces each)

Do you have any food allergies or intolerances? Yes _____ No _____
If so, what foods? _____

Please check all of the following health conditions or problems, which apply to you:

☐ Allergies ☐ Amenorrhea ☐ Anemia ☐ Anxiety ☐ Arthritis ☐ Asthma ☐ Back Pain ☐ Celiac Disease ☐ Chronic sinus condition ☐ Depression ☐ Disordered Eating ☐ Gastrointestinal disease (i.e. Crohn's, ulcers, etc) ☐ HIV/AIDS	☐ Heart disease/problems ☐ High blood pressure ☐ High blood sugar (diabetes) ☐ High cholesterol ☐ Immune system disease ☐ Insomnia ☐ Joint problems ☐ Kidney disease ☐ Liver problems ☐ Low blood pressure ☐ Lung disease/shortness of breath ☐ Major Surgeries: _____ _____	☐ Menopausal Symptoms ☐ Metabolic disease (PKU, etc) ☐ Neuromuscular disease (Parkinson's multiple sclerosis, etc.) ☐ Osteoporosis ☐ Past Injuries: _____ _____ ☐ Polycystic Ovary Disease ☐ Pregnancy ☐ Psychological problems ☐ Skin Problems ☐ Stroke ☐ Thyroid problems

List any other medical conditions not listed above:

_____

_____

List all medications you are currently taking (include over-the-counter drugs):

_____

_____

_____

_____

What are you interested in getting out of this program?

_____

_____

_____

_____

What are your personal goals that we can help you achieve?

_____

_____

_____

_____

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Quality of Life Scale

Directions: We are interested in knowing how your experience of having cancer affects your Quality of Life. Please answer all of the following questions based on your life **at this time**.

Please circle the number from 0 - 10 that best describe your experiences:

To what extent are the following a problem for you:

1. **Fatigue**
   severe problem 0 1 2 3 4 5 6 7 8 9 10 no problem

2. **Appetite changes**
   severe problem 0 1 2 3 4 5 6 7 8 9 10 no problem

3. **Aches or pain**
   severe problem 0 1 2 3 4 5 6 7 8 9 10 no problem

4. **Sleep changes**
   severe problem 0 1 2 3 4 5 6 7 8 9 10 no problem

5. **Weight gain**
   severe problem 0 1 2 3 4 5 6 7 8 9 10 no problem

6. Rate your **overall physical health**
   Extremely Poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

7. How difficult is it for you to **cope** today as a result of your disease?
   very difficult 0 1 2 3 4 5 6 7 8 9 10 not at all difficult

8. How difficult is it for you to **cope** today as a result of your treatment?
   very difficult 0 1 2 3 4 5 6 7 8 9 10 not at all difficult

9. How good is your **quality of life**?
   Extremely poor 0 1 2 3 4 5 6 7 8 9 10 Excellent

10. How much **happiness** do you feel?
    none at all 0 1 2 3 4 5 6 7 8 9 10 a great deal

11. Do you feel like you are **in control** of situations in your life?
    not at all 0 1 2 3 4 5 6 7 8 9 10 completely

12. How **satisfying** is your life?
    not at all 0 1 2 3 4 5 6 7 8 9 10 completely

13. How is your present ability to **concentrate or to remember** things?
    Extremely poor 0 1 2 3 4 5 6 7 8 9 10 excellent

Page score _____

14. How **useful** do you feel?
not at all 0 1 2 3 4 5 6 7 8 9 10 extremely

15. Has your illness or treatment caused negative changes in your **appearance**?
Extremely 0 1 2 3 4 5 6 7 8 9 10 not at all

16. Has your illness or treatment caused negative changes in the way you see yourself?
a great deal 0 1 2 3 4 5 6 7 8 9 10 not at all

How distressing were the following aspects of your illness and treatment?

17. **Initial diagnosis**
very distressing 0 1 2 3 4 5 6 7 8 9 10 not distressing

18. **Cancer surgery**
very distressing 0 1 2 3 4 5 6 7 8 9 10 not distressing

19. **Cancer treatment**
very distressing 0 1 2 3 4 5 6 7 8 9 10 not distressing

20. How much **anxiety** do you have?
a great deal 0 1 2 3 4 5 6 7 8 9 10 none at all

21. How much **depression** do you have?
a great deal 0 1 2 3 4 5 6 7 8 9 10 none at all

To what extent are you fearful of:

22. **Future diagnostic tests**
extreme fear 0 1 2 3 4 5 6 7 8 9 10 no fear

23. **A second cancer**
extreme fear 0 1 2 3 4 5 6 7 8 9 10 no fear

24. **Recurrence of cancer**
extreme fear 0 1 2 3 4 5 6 7 8 9 10 no fear

25. **Spreading (metastasis) of your cancer**
extreme fear 0 1 2 3 4 5 6 7 8 9 10 no fear

26. To what degree do you feel your life is back to **normal**?
not at all 0 1 2 3 4 5 6 7 8 9 10 a great deal

Social Concerns:

27. How distressing has your illness been for your **family**?
a great deal 0 1 2 3 4 5 6 7 8 9 10 not at all

28. Is the amount of **support** you receive from others sufficient to meet your needs?
not at all 0 1 2 3 4 5 6 7 8 9 10 a great deal

Page score _____

29. Is your continuing health care interfering with your **personal relationships**?
a great deal 0 1 2 3 4 5 6 7 8 9 10 not at all

30. To what degree has your illness and treatment interfered with your **employment**?
severe problem 0 1 2 3 4 5 6 7 8 9 10 no problem

31. To what degree has your illness and treatment interfered with your **activities at home**?
severe problem 0 1 2 3 4 5 6 7 8 9 10 no problem

32. How much **isolation** do you feel is caused by your illness?
a great deal 0 1 2 3 4 5 6 7 8 9 10 None at all

33. How much **concern** do you have for your family members getting cancer?
a great deal 0 1 2 3 4 5 6 7 8 9 10 None at all

34. How much **financial burden** have you incurred as a result of your illness and treatment?
a great deal 0 1 2 3 4 5 6 7 8 9 10 None at all

Spiritual Well Being:

35. How important to you is your participation in **religious activities** such as praying, going to church or temple?
not important 0 1 2 3 4 5 6 7 8 9 10 very important

36. How important to you are other **spiritual activities** such as meditation?
not important 0 1 2 3 4 5 6 7 8 9 10 very important

37. How much has your **spiritual life changed** as a result of cancer diagnosis?
None at all 0 1 2 3 4 5 6 7 8 9 10 a great deal

38. How much **uncertainty** do you feel about your future?
a great deal 0 1 2 3 4 5 6 7 8 9 10 None at all

39. To what extent has your illness made **positive changes** in your life?
None at all 0 1 2 3 4 5 6 7 8 9 10 a great deal

40. Do you sense a **purpose/mission** for your life or a reason for being alive?
None at all 0 1 2 3 4 5 6 7 8 9 10 a great deal

41. How **hopeful** do you feel?
Not at all 0 1 2 3 4 5 6 7 8 9 10 a great deal

Ferrell, Grant, Hassey-Dow, 1995

Page Score _____

TOTAL QOL SCORE _____

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Fatigue Survey

Please rate your fatigue by circling the one number that best describes your average personal experiences within the LAST WEEK. The rating of "0" is the lowest degree of fatigue (or fatigue is nonexistent) and the rating of "5" is the most severe/most common degree of fatigue.

1. **I tire easily**

   0 1 2 3 4 5
   Never Always

2. **I have an urge to lie down when doing daily activities**

   0 1 2 3 4 5
   Never Always

3. **I feel completely exhausted**

   0 1 2 3 4 5
   Never Always

4. **My body has a heavy and tired feeling**

   0 1 2 3 4 5
   Never Always

5. **Throughout my day, I seem to have a lack of energy**

   0 1 2 3 4 5
   Never Always

6. **I am reluctant to get out of bed**

   0 1 2 3 4 5
   Never Always

7. **I do not know what to do with myself**

   0 1 2 3 4 5
   Never Always

8. **I am fed up**

   0 1 2 3 4 5
   Never Always

9. **I have a lack of interests**

   0 1 2 3 4 5
   Never Always

10. I am careless

0	1	2	3	4	5
Never					Always

11. I am discouraged to do anything

0	1	2	3	4	5
Never					Always

12. I am forgetful

0	1	2	3	4	5
Never					Always

13. I make errors while speaking

0	1	2	3	4	5
Never					Always

14. I seem to be thinking slowly

0	1	2	3	4	5
Never					Always

15. I have trouble concentrating

0	1	2	3	4	5
Never					Always

TOTAL FATIGUE SCORE: _____

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Dear _____,

Your patient, _____, wishes to participate in LiveFit Cancer Exercise Program at The UNC Wellness Centers. This program is offered to provide instruction and guidance with exercise during the cancer recovery process. We would like to clarify that your patient **will not** be under medical supervision when exercising, but will be supervised in a small-group setting with similar participants/patients. Due to the nature of this patient's medical history, we are requesting medical clearance before accepting your patient into this program:

Date of Birth: ___/___/___

___ Heart trouble
___ Hypertension
___ COPD/breathing disorder
___ Diabetes
___ Immune deficiencies
___ Platelets < 90,000
___ ANC <1.5
___ Other (as explained by applicant):

___ Bone and joint problems
___ Seizure disorder/epilepsy/fainting spells
___ Frequent pains in heart/chest
___ Lymphedema
___ Severe Fatigue
___ Hematocrit <30
___ Adequate renal function with creatinine < 1.5

_____
_____
_____

*__Please indicate by checking one of the boxes below whether or not your patient can exercise without medical supervision.__

___ *May* exercise without medical supervision (Exercising in a small group format, utilizing all aspects of the fitness center).

___ *May **NOT*** exercise without medical supervision due to the reasons below:
_____
_____
_____

We are pleased that your patient has chosen to exercise with us and we appreciate your attention to this matter.

Sincerely,

Dustin Buttars, MA, ACSM HFS
Fitness Director
Please complete this form and fax to**:**
(984) 974-2590

_____ _____
Physician's Signature Date