Boulder Community Health

Outpatient Rehabilitation

Cancer Rehabilitation Exercise Class – Health History and Waiver

1. **First**_____ **MI**_____ **Last Name**_____
2. **Gender:** _____ **Date of Birth:**_____ **Age:**_____
3. **Address**_____ **Apt. #**_____
   City_____ **State** _____ **Zip**_____
4. **Phone:** ***home***_____ ***cell***_____ ***work***_____
5. **Email**_____
6. **In case of an emergency, please call:**
   Name_____ **Phone**_____
   Relationship_____
7. **Primary Physician:**
   Name_____ **Phone**_____
8. **Other Physicians:**
   Name_____ **Phone**_____
   Name_____ **Phone**_____
9. **Are you currently in treatment?** ❑ **Yes** ❑ **No**
   If yes, what kind?_____
   How often?_____
10. **When was your last treatment?**_____
11. **What is your cancer diagnosis?**_____
    a. **Stage:**_____
    b. **Date of diagnosis:**_____
12. **What treatments have you received for your cancer?**

❑ **Surgery**	❑ **Radiation**	❑ **Chemotherapy**
Location/Type: **Date:**	**Location/Type:** **Date:**	**Location/Type:** **Date:**
Location/Type: **Date:**	**Location/Type:** **Date:**	**Location/Type:** **Date:**
Location/Type: **Date:**	**Location/Type:** **Date:**	**Location/Type:** **Date:**

Please use the back of this sheet or another sheet of paper if you have had more treatments

13. Have you experienced side effects from your cancer treatments? ❑ Yes ❑ No

If yes, have you ever had any of the following side effects?

❑Bone Pain	❑Fatigue	❑Blood Clots	❑Cardiovascular Events	❑Skin Reaction
❑Joint Pain	❑Numbness/ Tingling	❑Sleep Problems	❑Swelling/ Lymphedema	❑Weakness
❑Incoordination/ Ataxia	❑Weight Changes	❑Hair Loss	❑Nausea/ Vomiting	❑Other:

14. Have you ever had any of the following?

		--------If yes, please describe-------
High Blood Pressure	❑ Y ❑ N	
Heart Attack	❑ Y ❑ N	
Stroke	❑ Y ❑ N	
Transient Ischemic Attack (TIA)	❑ Y ❑ N	
Chest Pain	❑ Y ❑ N	
Pacemaker	❑ Y ❑ N	
Diabetes Do you take insulin?	❑ Y ❑ N	
Peripheral Vascular Disease	❑ Y ❑ N	
Neuropathy/Decreased Sensation	❑ Y ❑ N	
Parkinson's Disease	❑ Y ❑ N	
Multiple Sclerosis	❑ Y ❑ N	
Polio/Post Polio Syndrome	❑ Y ❑ N	
Vestibular or Balance Problems	❑ Y ❑ N	
West Nile Virus	❑ Y ❑ N	
Respiratory Disease	❑ Y ❑ N	
Asthma	❑ Y ❑ N	
Seizures	❑ Y ❑ N	
Gastrointestinal Problems	❑ Y ❑ N	
Urinary Incontinence	❑ Y ❑ N	
Bowel Incontinence	❑ Y ❑ N	
Cancer	❑ Y ❑ N	
Osteoarthritis	❑ Y ❑ N	
Rheumatoid Arthritis	❑ Y ❑ N	
Fibromyalgia	❑ Y ❑ N	
Joint Replacement	❑ Y ❑ N	
Osteoporosis	❑ Y ❑ N	
Neck Pain	❑ Y ❑ N	
Low Back Pain	❑ Y ❑ N	
Are you currently pregnant?	❑ Y ❑ N	
Other:_____	❑ Y ❑ N	
Other:_____	❑ Y ❑ N	

15. Have you had any surgeries in the last year that are not listed above?

_____

_____

16. Do you wear eyeglasses? ❑ Yes ❑ No Do you wear hearing aids? ❑ Yes ❑ No

17. Do you use an assistive device for walking? ❑ Yes ❑ No

18. Can you stand up from the floor without someone assisting? ❑ Yes ❑ No

19. Do you need assistance for activities of daily living including walking, wheelchair propulsion, dressing, bathing, toileting, and/or eating? ❑ Yes ❑ No

20. Do you use a manual wheelchair? ❑ Yes ❑ No Do you use a power wheelchair? ❑ Yes ❑ No

21. Do you currently participate in regular exercise? ❑ Yes ❑ No

a. If yes, type:_____

b. Frequency:_____ Duration:_____

22. List any medications that you are currently taking including over the counter medications and vitamins/supplements:

Name	For what condition?

Please use the back of this sheet or another sheet of paper if you have more medications to record

18. Is there anything else you think we should know to help assure a safe and enjoyable class experience?

_____

19. How did you find out about this class?

_____

Please complete the participant release.

20. Participant Release:

I understand and agree that there are risks, both foreseeable and unpredictable, associated with any exercise program. I assume these risks and agree that my participation is at my own risk. I hereby agree that neither Boulder Community Health nor its respective directors, employees, agents or volunteers, shall assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in the Cancer Rehabilitation Exercise Class. I do hereby waive, release and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in the Cancer Rehabilitation Exercise Class. I understand that I should seek consultation from my doctor about whether I can safely participate in the class and whether there are precautions or limitations to my participation. I agree to use the equipment safely, as advised by a Boulder Community Health staff member.

Signature_____ Date_____

Thank you for taking the time to complete the above information. On the first day of class, please present to the instructor the completed forms and any written precautions/restrictions from your physician. We look forward to working with you.

If you have any questions, please contact Brandy Whitney at email bwhitney@bch.org.