Defer the Disease Exercise Program

WELCOME to our Program! We are excited to have you in this wonderful program and be able to offer it to you at an affordable cost!

By joining the FULL Defer the Disease Program you will receive:

• Fitness assessments twice during the program: one at the start and one at the end of the 3 months (pre & post assessment)

  NOTE: The Fitness Assessment is the first step in getting started with Defer the Disease®

  Your fitness assessment is scheduled for______________with________________________
  (DATE)   (Defer the Disease INSTRUCTOR)

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

• Participation in our weekly classes specifically designed for Individuals with Chronic Conditions.

• Personalized workout program based on your assessment results, limitations, and goals.

• Consultations with exercise specialist as needed for the duration of the program to discuss issues or concerns and to keep you on track.

• Three-month membership with Foothills Park & Recreation District (includes Fitness Land/Aqua Drop-in Classes)

• Special activities and lectures offered throughout the program for all participants.

• Opportunities to meet and socialize with other survivors and share stories, inspiration, motivation and friendship.

If not joining as a full membership, you must still complete paperwork and an initial assessment/follow-up, after which you can register for classes and/or individual trainings as desired to fit your needs.

The full price of this program is over $700. However, through the generous support from grants, fundraising events, corporate and private donations, and in kind support from participating facilities, we are able to offer this program to you at a discounted, rate of $200 (NonDistrict: $220) and for qualifying applicants, full or partial scholarships.

Here is a checklist to help get you started:

_____ Complete all the enclosed paperwork before your first meeting with the Defer the Disease® 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)409-2140.

_____ Bring all completed paperwork to your initial appointment.

_____ Submit the payment for the program-payment plans available

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

Contact Tami at 303-409-2114 (tamia@fhprd.org) if you have any questions.
Preparing for your Assessment:

During your fitness assessment, you will meet privately with your assigned Defer the Disease® 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 Blood Pressure/Heart Rate
- Circumference measurements
- Body Composition
- Balance
- Flexibility
- Muscular strength/endurance
- Cardiovascular endurance

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 computerized 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.
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? ________________________

____________________________________________________________________________

____________________________________________________________________________
What, if any, have been your roadblocks to maintaining an exercise program in the past? __________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Very Low</th>
<th>Low</th>
<th>Average</th>
<th>High</th>
<th>Very High</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking/running on the treadmill</td>
<td></td>
</tr>
<tr>
<td>Stationary/recumbent bike</td>
<td></td>
</tr>
<tr>
<td>Elliptical machines</td>
<td></td>
</tr>
<tr>
<td>Dumbbells</td>
<td></td>
</tr>
<tr>
<td>Elastic resistance bands/tubes</td>
<td></td>
</tr>
<tr>
<td>Weight machines</td>
<td></td>
</tr>
<tr>
<td>BOSUs/medicine balls/yoga balls</td>
<td></td>
</tr>
</tbody>
</table>

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

-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).

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

Chronic Condition History:
Please list any diagnosis/(es) you have had in the past (ie: cancer, Parkinson’s Disease, Cardiac issues, etc) along with dates of diagnosis and stages of progression:

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

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

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

Please describe any related surgeries you’ve had (type, date, recovery, lymph node dissection, reconstruction, etc):

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

Please describe any side effects of surgery:

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________

-Continued-
**Additional treatments (Chemotherapy/radiation/hormone therapy/immunotherapy, etc):**
Please describe any additional medical treatments you received and the schedule (type of drugs, how long, start/end dates, what method, how frequently, etc.):

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Do you currently have a port in place (chemotherapy/ostemy, etc)?** 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 condition/treatment?**
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Updated 1/2021
Health History Questionnaire

Name: ____________________________  Date: __________________

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

Explain each checked item: ________________________________________________

<table>
<thead>
<tr>
<th>HOSPITALIZATIONS/SURGERIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>List all reasons you were hospitalized Year</td>
</tr>
<tr>
<td>(excluding your cancer diagnosis/treatment)</td>
</tr>
<tr>
<td>1. ____________________________  _____</td>
</tr>
<tr>
<td>2. ____________________________  _____</td>
</tr>
<tr>
<td>3. ____________________________  _____</td>
</tr>
<tr>
<td>4. ____________________________  _____</td>
</tr>
<tr>
<td>5. ____________________________  _____</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ALL ALLERGIES REACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>(MEDICATIONS/FOODS/ETC)</td>
</tr>
<tr>
<td>1. ____________________________  __________________</td>
</tr>
<tr>
<td>2. ____________________________  __________________</td>
</tr>
<tr>
<td>3. ____________________________  __________________</td>
</tr>
<tr>
<td>4. ____________________________  __________________</td>
</tr>
<tr>
<td>5. ____________________________  __________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(List all medication you take on a regular basis including over the counter medications)</td>
</tr>
<tr>
<td>1. ____________________________  Reason: ____________________________</td>
</tr>
<tr>
<td>2. ____________________________  Reason: ____________________________</td>
</tr>
<tr>
<td>3. ____________________________  Reason: ____________________________</td>
</tr>
<tr>
<td>4. ____________________________  Reason: ____________________________</td>
</tr>
<tr>
<td>5. ____________________________  Reason: ____________________________</td>
</tr>
</tbody>
</table>

Updated 1/2021
Please circle any symptoms you are currently experiencing or mark the circle if you are not experiencing any of these symptoms.

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

The Defer the Disease exercise program is available to individuals with a variety of chronic conditions. This exercise program is an affordable, professionally directed exercise program for individuals with one or more chronic condition/s 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 3-month 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 Defer the Disease Program Coordinator during the 3 months 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 Defer the Disease, Foothills Park & Recreation District, 6612 S Ward St, Littleton, CO 80127 or fax it to Attention: Defer the Disease (303-409-2241). If you would like any additional information about this program, please call me at 303-409-2114.

Thank you for your cooperation.

Sincerely,
Tami Schlieman
Defer the Disease Program Coordinator

By signing below, I am authorizing my treating medical professional to release the requested information to Foothills Park and Recreation District Defer the Disease Program.

Participant Name: ___________________________________________ Date: _________________

Participant Signature: __________________________________________________________________________
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 Defer the Disease 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?

________________________________________________________________________
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.

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Has your doctor ever said that you have a heart condition OR high blood pressure?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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).</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5) Are you currently taking prescribed medications for a chronic medical condition?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>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 does not limit your current ability to be physically active. For example, knee, ankle, shoulder or other.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7) Has your doctor ever said that you should only do medically supervised physical activity?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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)
   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)?
   1c. Have you had steroid injections or taken steroid tablets regularly for more than 3 months?

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?
   2b. Are you currently receiving cancer therapy (such as chemotherapy or radiotherapy)?

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)
   3b. Do you have an irregular heart beat that requires medical management?
       (e.g., atrial fibrillation, premature ventricular contraction)
   3c. Do you have chronic heart failure?
   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)
   3e. Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?

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)
   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?
   4c. Do you have other metabolic conditions (such as thyroid disorders, pregnancy-related diabetes, chronic kidney disease, liver problems)?

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)
   5b. Do you also have back problems affecting nerves or muscles?
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.
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.

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.

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 or Canadian Society for Exercise Physiology www.csep.ca

Citation for PAR-Q+

Key References

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

PART 1. 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:

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<th>HOW SATISFIED ARE YOU WITH:</th>
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© Copyright 1984 & 1998 Carol Estwing Ferrans and Marjorie J. Powers
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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.

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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

Updated 1/2021
Lymphedema Informative Sheet

What is the lymph system?
- 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—also called Lymph nodes.
- Lymph nodes serve as filters for harmful substances and help us fight infection.

What is lymphedema?
- 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.
- Lymphedema can occur as a result of cancer, cancer treatments, or anything that changes a normal, healthy lymph system.
  - 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.
- Whether or not a person develops lymphedema depends on a variety of factors:
  - Type of cancer
  - Treatment types and extent of lymph system involvement
  - Each individual’s body system

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 Defer the Disease Exercise Specialist or your physician.