Association: Branch:

LIVESTRONG®
FOUNDATION

LIVESTRONG® AT THE YMCA INTAKE FORM

PARTICIPANT INFORMATION

Name:		Date (DD/MM/YY): / /
Preferred phone number:	Email:	Preferred contact method: ☐ Phone ☐ Email
Where were you treated?		
Physician name:		

1. **Date of birth** (DD/MM/YY): ____/____/________

2. **Gender:** ☐ Male ☐ Female

3. **Are you Hispanic, Latino/a, or Spanish origin?** [One or more categories may be selected]

   ☐ No, not of Hispanic, Latino/a, or Spanish origin
   ☐ Yes, Mexican, Mexican American, Chicano/a
   ☐ Yes, Puerto Rican
   ☐ Yes, Cuban
   ☐ Yes, Another Hispanic, Latino/a or Spanish origin

4. **What is your race?** [One or more categories may be selected]

   ☐ White
   ☐ Black or African American
   ☐ American Indian or Alaska Native
   ☐ Asian Indian
   ☐ Chinese
   ☐ Filipino
   ☐ Japanese
   ☐ Korean
   ☐ Vietnamese
   ☐ Other Asian
   ☐ Native Hawaiian
   ☐ Guamanian or Chamorro
   ☐ Samoan
   ☐ Other Pacific Islander

5. **How did you learn about the LIVESTRONG® at the YMCA cancer survivorship program?**

   ☐ Y staff member or volunteer
   ☐ A friend or family member or word of mouth
   ☐ A doctor or other health care professional
   ☐ A local or national cancer awareness or support organization or event
   ☐ A mailing or email communication
   ☐ A poster, or flyer or event at the Y
   ☐ A poster or flyer at a cancer or medical center
   ☐ The Y's website
   ☐ LIVESTRONG
   ☐ Media (TV, web, radio, print, etc.)
   ☐ Other (please specify): ______________________________