

# The Rural Exercise for Cancer Patients and Survivors (RECaPS) Study

## Investigators:

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## Instructions:

Thank you for agreeing to participate in this study. In this questionnaire, we are going to ask you a series of questions about yourself. This part of the questionnaire collects important information regarding the characteristics and needs of people diagnosed with cancer and living in the greater Huntsville area.

Many of the questions ask you about your current health and health history, and some may be viewed as personal. It is important to answer as many of these questions as possible; however, you may leave questions blank if you are uncomfortable answering them.

**Please Note:** All responses are completely confidential and will never be used in any way that could link them to you. By returning this questionnaire, you are providing consent for the study Investigators to use your data anonymously.

If you have any questions about completing the questionnaire, please contact our Exercise Lead (Deanna Lavigne) or our Research Coordinator (Lisa Allen) at 705-789-2311 x 2712 or [therecapsstudy@gmail.com](mailto:therecapsstudy@gmail.com).

## DEMOGRAPHICS

1. Age: \_\_\_\_\_

2. Location of Residence (in relation to downtown Huntsville):

downtown	_____	10-minute drive	_____	30-minute drive	_____
5-minute drive	_____	20-minute drive	_____	40+ minute drive	_____

3. Current Marital Status:

Never Married	_____	Married	_____	Common Law	_____
Separated	_____	Widowed	_____	Divorced	_____

4. Education (Please check highest level attained):

Some High School	_____	Completed High School	_____	Some University/College	_____
Completed Univ/Coll	_____	Some Graduate School	_____	Completed Grad School	_____

**5. Annual Family Income:**

< \$20,000 \_\_\_\_\_ \$20-39,999 \_\_\_\_\_ \$40-59,999 \_\_\_\_\_  
\$60-79,999 \_\_\_\_\_ \$80-99,999 \_\_\_\_\_ > \$100,000 \_\_\_\_\_

**6. Current Employment Status:**

Disability \_\_\_\_\_ Retired \_\_\_\_\_ Part Time \_\_\_\_\_  
Full Time \_\_\_\_\_ Sick Leave \_\_\_\_\_

**7. What is your primary ethnic origin or race (please circle)?**

White Black Hispanic Asian Aboriginal Other \_\_\_\_\_

**8. Which of the following best describes your current smoking status?**

Never Smoked \_\_\_\_\_ Ex-Smoker \_\_\_\_\_ Current Smoker \_\_\_\_\_

**9. Has a doctor or nurse ever told you that you had any of the following conditions? (check all that apply):**

High blood pressure	_____ No	_____ Yes	High cholesterol	_____ No	_____ Yes
Heart attack	_____ No	_____ Yes	Stroke	_____ No	_____ Yes
Emphysema	_____ No	_____ Yes	Chronic bronchitis	_____ No	_____ Yes
Diabetes	_____ No	_____ Yes	Other cancer	_____ No	_____ Yes
Angina (chest pains)	_____ No	_____ Yes	Arthritis	_____ No	_____ Yes

Any other long-term health condition? \_\_\_\_\_

**10. In the past month, was your ability to exercise limited by a health condition, injury, or disability?**

1	2	3	4	5
Not at all	A little	Somewhat	Quite a lot	Completely

**11. Are you currently taking any medications for health problems? (e.g., for anxiety, depression, blood pressure, constipation, pain, to help with sleep, etc.)**

What is the medication?	What is it for? (e.g., blood pressure, anxiety)
1. _____	_____
2. _____	_____
3. _____	_____
Others? _____	

**12. Have you experienced any recent weight loss or gain? (please check)**

**12a. Weight loss?**    ☐ Yes    ☐ No                      **12b. Weight gain?**    ☐ Yes    ☐ No

If Yes, how much? \_\_\_\_\_ If Yes, how much? \_\_\_\_\_

**13. Please rate the average level of fatigue you currently experience within a typical day.**

0	1	2	3	4	5	6	7	8	9	10
None		Mild			Moderate			Severe		Extreme

**CANCER HISTORY**

**1. What type of cancer were you diagnosed with (most recent)?**

\_\_\_\_\_

**2. When were you diagnosed with this type of cancer (month/year)?**

\_\_\_\_\_

**3. Did your cancer involve the lymph nodes? (please check)**

☐ Yes    ☐ No    ☐ Unsure

**4. Was your cancer described as “localized” (confined to one area of the body) or “metastasized” (spread to other parts of the body)?**

☐ Localized    ☐ Metastasized    ☐ Unsure

**5. If your cancer was described as metastasized, where else in your body was it? (check all that apply)**

<input type="checkbox"/> Lung	<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Brain	<input type="checkbox"/> Liver
<input type="checkbox"/> Bone	<input type="checkbox"/> Other (Please specify: _____)		<input type="checkbox"/> Unsure

**6. Did your treatment involve surgery? (please check)**

☐ Yes    ☐ No

If Yes, please provide the following details of your surgery or surgeries:

**6a. How many surgeries:** \_\_\_\_\_

**6b. Area(s) of your body:** \_\_\_\_\_

**6c. Surgery dates [month(s)/year(s)]:** \_\_\_\_\_

**7. Did your treatment involve radiation therapy? (please check)**

☐ Yes    ☐ No

If **Yes**, please provide the following details of your radiation therapy:

**7a. How many treatments:**

\_\_\_\_\_

**7b. Area(s) of your body treated:**

\_\_\_\_\_

**7c. What was the date of your last treatment (month/year):**

\_\_\_\_\_

**8. Did your treatment include chemotherapy? (please check)**

\_\_\_\_\_ Yes      \_\_\_\_\_ No

If **Yes**, please provide the following details of your chemotherapy treatment:

**8a. What type(s) of chemotherapy did you receive?**

\_\_\_\_\_

**8b. How many treatments (of each type) did you receive?**

\_\_\_\_\_

**8c. What was the date of your last treatment (month/year)?**

\_\_\_\_\_

**9. Did you receive any other type of treatment? (please check)**

\_\_\_\_\_ Yes      \_\_\_\_\_ No

If **Yes**, please provide the following details of your other treatments:

**Additional Treatment #1**

**9a. What type of treatment?**

\_\_\_\_\_

**9b. How many treatments did you receive?**

\_\_\_\_\_

**9c. What was the date of your last treatment?**

\_\_\_\_\_

**Additional Treatment #2**

**9d. What type of treatment?**

\_\_\_\_\_

**9e. How many treatments did you receive?**

\_\_\_\_\_

**9f. What was the date of your last treatment?**

\_\_\_\_\_

**10. What is the current status of your cancer treatments? (please check)**

\_\_\_\_\_ I am not currently receiving any cancer treatments.

\_\_\_\_\_ I am currently receiving cancer treatment.

If currently receiving cancer treatment, what treatment(s)? \_\_\_\_\_

**11. Have you ever had a recurrence of your cancer? (please check)**

\_\_\_\_\_ Yes      \_\_\_\_\_ No      \_\_\_\_\_ Unsure

**12. Is this the only type of cancer you have been diagnosed with? (please check)**

\_\_\_\_\_ Yes      \_\_\_\_\_ No

**13. If No, please list the other types of cancer, dates of diagnosis (month/year), and types/details of the treatments received in the space below:**

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**14. Do you have any complications due to treatment? (please check)**

\_\_\_\_\_ Yes      \_\_\_\_\_ No

If Yes, please list (e.g., infections, low blood counts, muscle/bone/joint pain):

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## **RECaPS NEEDS ASSESSMENT**

**PART 1: Please answer the following questions:**

- 1. During a typical 7-day period in the last month, how often do you take part in the following kinds of exercise during your free time and for how long?**

**STRENUOUS EXERCISE - Heart beats rapidly**

*(e.g. running, jogging, hockey, football, soccer, squash, basketball, vigorous swimming or bicycling)*

Number of times per week \_\_\_\_\_

Average duration of each session (minutes) \_\_\_\_\_

**MODERATE EXERCISE - Not exhausting**

*(e.g. fast walking, easy bicycling, easy swimming, downhill skiing)*

Number of times per week \_\_\_\_\_

Average duration of each session (minutes) \_\_\_\_\_

**MILD EXERCISE - Minimal effort**

(e.g. yoga, taking the stairs, bowling, easy walking)

Number of times per week \_\_\_\_\_

Average duration of each session (minutes) \_\_\_\_\_

**RESISTANCE / STRENGTH EXERCISE**

(e.g., lifting weights, push ups, sit ups, resistance bands)

Number of times per week \_\_\_\_\_

Average duration of each session (minutes) \_\_\_\_\_

**2. In general, I engage in exercise (check any that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Alone                        | <input type="checkbox"/> With family or friends |
| <input type="checkbox"/> With an organized group      | <input type="checkbox"/> At home                |
| <input type="checkbox"/> At a gym or community centre | <input type="checkbox"/> Outside                |
| <input type="checkbox"/> At a medical facility        |   |

**3. Describe your physical activity level during the following times:**

**Prior to your cancer diagnosis**

- |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not active at all        | A little active          | Somewhat active          | Very active              |

**During your cancer treatment**

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not active at all        | A little active          | Somewhat active          | Very active              | Not applicable           |

**After your cancer treatment**

- |                          |                          |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Not active at all        | A little active          | Somewhat active          | Very active              | Not applicable           |

**4. What were the barriers to exercise participation *during* your cancer treatment? (check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Cost   | <input type="checkbox"/> Unaware of any available exercise program |
| <input type="checkbox"/> Time   | <input type="checkbox"/> Distance to exercise program              |
| <input type="checkbox"/> Child care                                       | <input type="checkbox"/> Transportation                            |
| <input type="checkbox"/> Physical side effects (if checked, please list): | _____  |

- ☐ Other (please describe): \_\_\_\_\_

**5. What were the barriers to exercise participation *after* your cancer treatment? (please check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Cost   | <input type="checkbox"/> Unaware of any available exercise program |
| <input type="checkbox"/> Time   | <input type="checkbox"/> Distance to exercise program              |
| <input type="checkbox"/> Child care   | <input type="checkbox"/> Transportation                            |
| <input type="checkbox"/> Physical side effects (if checked, please list): _____ |  |

☐ Other (please describe): \_\_\_\_\_

**6. Were you informed about the benefits of exercise by your health care team?**

- ☐ Yes ☐ No

**7. If yes, which member of your team discussed exercise with you?**

- |   |   |
|---|---|
| <input type="checkbox"/> Surgeon                        | <input type="checkbox"/> Medical Oncologist |
| <input type="checkbox"/> Radiation Oncologist           | <input type="checkbox"/> Nurse              |
| <input type="checkbox"/> Physiotherapist                | <input type="checkbox"/> Kinesiologist      |
| <input type="checkbox"/> Family Doctor                  |   |
| <input type="checkbox"/> Other (please describe): _____ |   |

**8. Do you feel participation in an exercise program would be beneficial for you at this time?**

- ☐ Yes ☐ No ☐ Unsure

**9. Please explain your response to question #8 (why do you feel this way?).**

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**10. How confident are you that you could exercise three to five times per week for 30-60 minutes during each session? (please circle)**

Not confident

Extremely confident

1      2      3      4      5      6      7      8      9      10

**11. Do you currently have any side effects of treatment?**

- ☐ Yes ☐ No

**12. If you answered yes to question 11, please check all of the side effects that apply:**

- |  |   |
|--|---|
| <input type="checkbox"/> Fatigue                                     | <input type="checkbox"/> Lymphedema       |
| <input type="checkbox"/> Depression                                  | <input type="checkbox"/> Anxiety          |
| <input type="checkbox"/> Nausea / Vomiting                           | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Pain (if checked, please list location(s)): |   |

\_\_\_\_\_

- ☐ Decreased strength (if checked, please list location(s)):

\_\_\_\_\_

- ☐ Decreased range of motion (if checked, please list location(s)):

\_\_\_\_\_

- ☐ Other (if checked, please list):

\_\_\_\_\_

**13. If you answered yes to question 11, please describe how these side effects have affected your function:**

- ☐ Unable to return to work (if checked, list occupation):
- \_\_\_\_\_
- ☐ Unable to return to important activities at home
- ☐ Unable to return to important activities in the community
- ☐ No change in function
- ☐ Other (please describe):
- \_\_\_\_\_

**14. What are your cancer-related concerns at this time?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**15. Do you feel involvement in an exercise program could help these concerns?**

- ☐ Yes ☐ No

**16. Which of the following best describes you right now? I want to...**

- ☐ Increase my current level of physical activity



- ☐ Maintain my current level of physical activity
- ☐ Decrease my current level of physical activity
- ☐ I do not currently have goals related to my physical activity

**17. What would motivate you to participate in an exercise program at this time? (check all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Increase fitness level         | <input type="checkbox"/> Reduce stress   |
| <input type="checkbox"/> Increase social interaction    | <input type="checkbox"/> Prevent disease   |
| <input type="checkbox"/> Lose weight                    | <input type="checkbox"/> Improve ability to do things that matter to me<br>(e.g., social activities with family and friends) |
| <input type="checkbox"/> Prevent cancer recurrence      | <input type="checkbox"/> Increase strength   |
| <input type="checkbox"/> Other (please describe): _____ |  |

**18. What would help you to successfully participate in exercise at this time? (check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Access to a gym                                    | <input type="checkbox"/> Access to exercise equipment |
| <input type="checkbox"/> Social support                                     | <input type="checkbox"/> Transportation assistance    |
| <input type="checkbox"/> Information from a qualified exercise professional |   |
| <input type="checkbox"/> Other (please list): _____                         |   |

**19. Do you currently have access to a gym at your home?**

- ☐ Yes ☐ No

**20. Are you currently a member of a gym or fitness centre?**

- ☐ Yes ☐ No

**21. Would you like to participate in the RECaPS exercise program at this time or within the next two years?**

- ☐ Yes ☐ No ☐ Unsure

**PART 2: If you declined to participate in the RECaPS Exercise Program, could you please answer the following questions:**

**1. Why did you decline to participate in the RECaPS exercise program?**

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**2. What are your current barriers to participating in this study?**

- |   |  |
|---|--|
| <input type="checkbox"/> Cost   | <input type="checkbox"/> Unaware of any available exercise program |
| <input type="checkbox"/> Time   | <input type="checkbox"/> Distance to exercise program              |
| <input type="checkbox"/> Child care                                       | <input type="checkbox"/> Transportation                            |
| <input type="checkbox"/> Physical side effects (if checked, please list): |  |

☐ Other (please describe):

**3. How could the RECaPS exercise program be modified to help you overcome the barriers you listed above?**

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