



Wellness Center Application and Health History Questionnaire

Date: ____/____/____

12 High Street, Lower Level, Lewiston, ME 04240 • Tel: 207-795-2473 • Fax: 207-795-5789 • prevention@cmhc.org

- Membership
 Aerobic Punch Card
 Personal Training
 Nutrition Counseling
 Wellness for Life
 Bariatrics

Are you a CMMF employee or affiliate?
 No
 Yes
Please specify: _____

CONTACT INFORMATION			
NAME: _____		DATE OF BIRTH: ____ / ____ / ____	
[LAST]	[FIRST]	[MI]	
MAILING ADDRESS: _____		CITY: _____	STATE: ____ ZIP: _____
TEL: (H) _____	(W) _____	E-MAIL: _____	
EMERGENCY CONTACT: _____		TEL: _____	RELATION: _____
PHYSICIAN'S NAME: _____		PRACTICE NAME: _____	
TEL: _____		FAX: _____	

Why do we ask for this information? This is a medically-integrated Wellness Center providing high quality, personalized services to clients having diverse health and wellness needs. The information below allows us to serve you with optimal and appropriate care and attention. Confidentiality is protected as per the Health Insurance Portability and Accountability Act (HIPAA) and the Central Maine Medical Center policy on Privacy Practices.

HEALTH HISTORY			
<i>Please check all that apply</i>	Yes	No	<i>Please explain</i>
Have you ever been told you have a heart condition?	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Heart Murmur</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Mitral Valve Prolapse</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Abnormal EKG</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Angina Pectoris (chest pain)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Congestive Heart Failure</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Heart Attack (myocardial infarction or thrombosis)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Have you ever had any kind of heart surgery?</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been told you have High Blood Pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Are you following a diet as recommended by a healthcare professional to control your blood sugar?</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a thyroid condition?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have respiratory problems <i>(e.g., asthma, emphysema, COPD)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a history of epilepsy or seizures?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever been diagnosed with cancer? <i>(please specify)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
Are you currently in treatment for cancer?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any or chronic orthopedic/musculoskeletal limitations?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you, or is there a chance that you may be, pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have chronic back or neck pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Other <i>(please specify)</i>	<input type="checkbox"/>	<input type="checkbox"/>	

MEDICATIONS

Please list any medications you are now taking. Include over-the-counter medicines and allergy remedies. (Continue on back of paper, if necessary.)

MEDICATION	DOSAGE	PURPOSE

FAMILY MEDICAL HISTORY

FAMILY HISTORY	Has any member of your immediate family (father, mother, brother, sister) ever had ...	Yes	No	Please explain
	Heart problems (heart attack, chest pain or angina, bypass surgery, angioplasty...) prior to the age of 50? <i>If yes, please describe (relation, heart problem, age of onset)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
	Diabetes? <i>If yes, please describe:</i>	<input type="checkbox"/>	<input type="checkbox"/>	
	High blood pressure? <i>If yes, please describe:</i>	<input type="checkbox"/>	<input type="checkbox"/>	

YOUR DAILY HEALTH

		Yes	No
Have you ever used tobacco? (including smokeless tobacco) If yes, at what age did you start? _____ If you quit, at what age? _____		<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco now? If yes, what do you use and how much? _____		<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a problem controlling your weight?		<input type="checkbox"/>	<input type="checkbox"/>
Since age 21, what is the most/least you have ever weighed? Most: _____ Least: _____			
Do you follow any special diet at this time? If yes, please describe: _____		<input type="checkbox"/>	<input type="checkbox"/>
What best represents the amount of stress you experience in your daily life: <input type="checkbox"/> No stress <input type="checkbox"/> Occasional mild stress <input type="checkbox"/> Frequent moderate stress <input type="checkbox"/> Frequent high stress <input type="checkbox"/> Constant high stress			
Do you know what your Total Cholesterol level is? If yes, what is it? _____		<input type="checkbox"/>	<input type="checkbox"/>
Do you consume alcoholic beverages? If yes, how many do you drink per week? <input type="checkbox"/> 1-5 drinks <input type="checkbox"/> 6-10 drinks <input type="checkbox"/> 11-15 drinks		<input type="checkbox"/>	<input type="checkbox"/>

By joining the Wellness Center, I would like to accomplish the following goals (e.g., decrease body fat, increase endurance, tone...)

1. _____
2. _____
3. _____
4. _____

I hereby verify that to the best of my knowledge the information I have provided on this document is accurate, and furthermore agree to inform the Wellness Center Staff of any changes in my health status.

Signature

Date

All responses are confidential. This form will be maintained as part of your permanent Wellness Center record and shall not be released without your written consent.

ACKNOWLEDGEMENT OF RESPONSIBILITY, RELEASE FROM LIABILITY, AND INDEMNIFICATION AGREEMENT

I, _____, hereby acknowledge and agree that my use of the facilities, equipment, supplies, and personal services of the Wellness Center is entirely voluntary and for recreational and personal purposes. I understand and agree that my use of the Wellness Center is not a requirement of my employment, nor is it part of my job. I understand and agree that whether or not I use the Wellness Center during my regular working hours, any time spent at the Wellness Center is not working time, and even if I'm permitted to take time off from my job duties to use the Wellness Center, this does not arise out of my employment, and is not in the course of my employment.

PLEASE INITIAL HERE TO INDICATE THAT YOU UNDERSTAND AND AGREE WITH THE ABOVE STATEMENTS: _____

I further understand and acknowledge that engaging in physical exercise and exertion, and the use of physical fitness equipment, can involve significant risk of injury. I understand that it is my responsibility to confer with my personal physician before using the facilities and equipment of the Wellness Center. I further understand that engaging in physical exercise and the use of the fitness equipment involves inherent risks including, but not limited to, cardiac problems, stroke, injuries to the muscular system, and orthopedic and other injuries arising from stress, strain, falls, collisions, or mishaps with equipment. **I understand that use of the physical fitness equipment in this facility is under my own power and free of outside assistance.** I understand these risks, and I assume full responsibility for proceeding in the face of these risks.

PLEASE INITIAL HERE TO INDICATE THAT YOU UNDERSTAND AND AGREE WITH THE ABOVE STATEMENTS: _____

RELEASE AND INDEMNIFICATION

I hereby release Central Maine Healthcare Corporation, Central Maine Medical Center, the Wellness Center, and their affiliated corporations, and the officers, directors, employees, and agents of each of them, from any claim of any kind whatsoever, arising from any injury, or claim of injury, arising from my use of the facilities, equipment, supplies, or personal services of the Wellness Center. This release expressly includes negligence of Central Maine Medical Center, Central Maine Healthcare Corporation, the Wellness Center, their affiliated corporations, and the officers, directors, employees, and agents of each of them.

I further agree not to cause or permit any claim or lawsuit to be filed against Central Maine Healthcare Corporation, Central Maine Medical Center, the Wellness Center, or any affiliated corporation, or the offices, directors, employees, or agents of any of them, based on any claim arising from any injury arising from my use of the facilities, equipment, supplies or personal services of the Wellness Center. I hereby agree that in the event that any such claim or lawsuit is filed against any of the organizations or individuals specified above, and such claim or lawsuit is ultimately dismissed or judgment is entered in favor of such organization or individual, I will INDEMNIFY and hold harmless each such organization and individual against all fees and costs incurred in defending any such claim or lawsuit, including reasonable attorney fee.

I HAVE CAREFULLY READ THIS ACKNOWLEDGEMENT OF RESPONSIBILITY, RELEASE FROM LIABILITY, AND INDEMNIFICATION AGREEMENT, AND I UNDERSTAND THAT I AM VOLUNTARILY CHOOSING TO ASSUME THE RISK OF USING THE WELLNESS CENTER, THAT I MAY BE FORFEITING OR FOREGOING CERTAIN LEGAL RIGHTS, AND THAT I AM VOLUNTARILY AGREEING TO RELEASE CLAIMS WHICH I MAY HAVE IN THE FUTURE.

Signature of Participant

Signature of Witness

Participant's Name (Please Print)

Witness Name (Please Print)

Date: _____

HOW DID YOU HEAR ABOUT US?

- Daily Newspaper Weekly/Monthly Newspaper Radio/Television Internet Friend/Family
- Physician Referral _____ Other _____

ONCOLOGY PATIENTS

I further understand and acknowledge that my oncologist or primary care physician is referring me to participate in "Wellness for Life": A Program for Cancer Patients jointly offered by the Wellness Center and the Comprehensive Cancer program at Central Maine Medical Center. I understand this program can include, but is not limited to personal training, personal fitness, group exercise, Pilates, yoga, and group wellness discussions. I understand that my program may be assessed with data collected on an on-going basis through patient, physician, and counselor questionnaires, measurable physical assessment data, and quality of life indicators.

PLEASE INITIAL HERE TO INDICATE THAT YOU UNDERSTAND AND AGREE WITH THE ABOVE STATEMENTS. _____

Referring Party Signature

Date

Referring Party Name (please print)

Title