



## HEALTH COACHING MEMBERSHIP APPLICATION

### PROGRAM ELIGIBILITY

Health YOUiversity programs and services are available to WellPoint associates that work in locations without onsite Wellness Centers, or to WellPoint associates that are considered full-time work at home.

Please check this box to confirm your Health YOUiversity program eligibility.

***The Health YOUiversity Staff will treat your health information as offered in the Membership Application carefully and confidentially. It will not be revealed to anyone outside Health YOUiversity without your written consent. The information may be used in aggregate membership data reporting only when your identity is kept confidential. Accurate completion of this application is required for membership to Health YOUiversity.***

**Please send your completed application to [Suzanna.allen@wellpoint.com](mailto:Suzanna.allen@wellpoint.com) or 206.338.3645 (FAX).**

**Please continue on the next page.**



## Your WellPoint Wellness Program Health Coaching Membership Application

### PERSONAL/WORK INFORMATION

Last Name			First Name			M.I.
Gender (M/F)	Age	Height	Weight	Associate ID*	Birthdate	
Home Address					Apt.	
City			State	Zip		
Home Phone		Emergency Phone		Emergency Contact		
Work Location (mailpoint), City, State		Work Number		Work E-mail		
May a health coach contact you by phone: <input type="checkbox"/> Yes <input type="checkbox"/> No - by selecting this box, you are requesting email contact only Please note, contacts will be made/accepted between 8:00am-4:00pm EST Mon-Fri						
Please check the following health coaching services of interest (please note, your interests can change at any time): <input type="checkbox"/> Working with a Fitness Coach <input type="checkbox"/> Working with a Registered Dietitian <input type="checkbox"/> Working with both						

*\*Your associate ID can be found by going to the WorkNet site- View my paycheck or Enter My Time (on the left hand side of the screen) or if you look at your paycheck, it is the number below your social security number. It is a 6 or 7 digit number starting with 0 or 1. All 0s are important and must be entered.*

### PHYSICIAN *Please list your personal physician.*

Physician's Name*		Phone*	Fax*
Physician's Address			

*\*Please be advised that we may need to consult with your physician in order to provide optimum health services. It is mandatory that you provide the name, phone number, and fax number for your current physician.*

### Current Medications

Name of Medication	Reason for Taking	Name of Medication	Reason for Taking
<b>Are you allergic to any medication?</b>	No <input type="checkbox"/>	Yes (Explain) <input type="checkbox"/>	

**Please continue on the next page.**

## Health History Questionnaire

**Personal History - ACSM Medical Status: Do you have, or have you ever had, any of the following?**

	Yes	No		Not Sure	Yes	No
Coronary or atherosclerotic disease	<input type="checkbox"/>	<input type="checkbox"/>	Rapid throbbing or fluttering of the heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Severe pain in leg muscles during walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic swelling of the feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Known heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Total cholesterol greater than 200mg/dl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Total HDL greater than 60mg/dl (benefit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Fasting blood sugar greater than 100mg/dl (confirmed on at least two occasions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or discomfort in the chest	<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure greater than 140/90mmHg (confirmed on at least two occasions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unaccustomed shortness of breath (perhaps during light exercise)	<input type="checkbox"/>	<input type="checkbox"/>	Family history of cardiac or pulmonary disease prior to age 55	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Currently smoke cigarettes or cigars or use smokeless tobacco products or have quit in the past 6 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing while standing or sudden breathing problems at night	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a sedentary lifestyle (no regular exercise)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a recent or serious illness not accounted for in the statements above?				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>If the answer to ANY of the above is yes, please explain and give dates:</i></b>						

## Physical Activity Readiness Questionnaire (PAR-Q)

PAR-Q is designed to help you help yourself. Many health benefits are associated with regular exercise, and the completion of PAR-Q is a sensible first step to take if you are planning to increase the amount of physical activity in your life. For most people physical activity should not pose any problem or hazard. PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them. Common sense is your best guide in answering these few questions. Please read them carefully and check the correct answer for each question as it applies to you.

- |                          |                          |  |
|--------------------------|--------------------------|--|
| Yes                      | No                       |  |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said you have a heart condition AND that you should only do physical activity recommended by a doctor?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you feel pain in your chest when you do physical activity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. In the past month, have you had chest pain when you were not doing physical activity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you lose your balance because of dizziness or do you ever lose consciousness?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Is your doctor currently prescribing medications (for example, water pills) for your blood pressure or for a heart condition? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you know of any other reason why you should not do physical activity?  |

***If you answered "yes" to any of these questions, it is strongly suggested that you see your physician before you begin this program. In some cases, a physician's consent form may be required prior to certain Health YOUUniversity activities and services.***

**Please continue on the next page.**



## Your WellPoint Wellness Program Health Coaching Membership Application

### Personal History – Medical, Health, and Lifestyle Questionnaire: *Do you have, or have you ever had, any of the following?*

	Yes	No		Yes	No
High blood pressure Avg. blood pressure = _____ / _____	<input type="checkbox"/>	<input type="checkbox"/>	Foot/Ankle problems	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal EKG	<input type="checkbox"/>	<input type="checkbox"/>	Knee problems	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder problems	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Recently (in past 6 months) broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Chronic headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>
Other lung problems	<input type="checkbox"/>	<input type="checkbox"/>	Persistent fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Limited range of motion	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Swollen or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	Currently pregnant, due date	<input type="checkbox"/>	<input type="checkbox"/>
<b>If the answer to ANY of the above is yes, please explain and give dates:</b>					
<b>Have you ever been hospitalized with any illness, surgery, procedure, or injury?</b>				<input type="checkbox"/>	<input type="checkbox"/>
<b>If yes, please explain and give dates:</b>					

### Family History

*Do any of your immediate family members have or have they ever had any of the following?*

	Yes	No	Relation (check all that apply)	Age(s)
Heart attack, angioplasty or heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother	
Sudden cardiac death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother	
Congenital (at birth) heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother	
Leukemia or cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sister <input type="checkbox"/> Brother	
<input type="checkbox"/> Check here if your family history is unknown.				

**Please explain your health goals. What do you want from Health YOUiversity?**

**Please continue on the next page.**

### Lifestyle Choices Questionnaire

**Over the past six months, on average, please describe your level of physical activity.**

**Number of days per week** (check one)     1     2     3     4     5     6     7

**Number of minutes per day** (check one)     15     30     45     60+

**Intensity Level**     Light     Moderate     Hard

**Type of Activity –** Select the one which is most applicable to you.

<input type="checkbox"/> Taking stairs, casual walking, playing with children, gardening	<input type="checkbox"/> Walking, biking, other planned cardiovascular exercise	<input type="checkbox"/> Variety of planned cardiovascular, strength, and stretching exercises
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**Exercise Interests:** \*Please check any of the following activities that interest you *and* that are available for your use.

<input type="checkbox"/> Aerobics	<input type="checkbox"/> Outdoor Cycling	<input type="checkbox"/> Walking	<input type="checkbox"/> Other
<input type="checkbox"/> Running	<input type="checkbox"/> Swimming	<input type="checkbox"/> Treadmill	<input type="checkbox"/> Other
<input type="checkbox"/> Elliptical	<input type="checkbox"/> Spinning	<input type="checkbox"/> Stationary Cycle	<input type="checkbox"/> Other
<input type="checkbox"/> Weight Machines	<input type="checkbox"/> Exercise Ball	<input type="checkbox"/> Dumbbells	<input type="checkbox"/> Other

**Exercise Goals:** \*Please check any of the following goals you would like to achieve.

<input type="checkbox"/> Aerobic Fitness/Endurance	<input type="checkbox"/> Feel Better	<input type="checkbox"/> Sport Specific	<input type="checkbox"/> Stop Smoking
<input type="checkbox"/> Improve Eating Habits	<input type="checkbox"/> Gain Weight	<input type="checkbox"/> Flexibility	<input type="checkbox"/> General Fitness
<input type="checkbox"/> Lower Cholesterol	<input type="checkbox"/> Injury Rehab	<input type="checkbox"/> Look Better	<input type="checkbox"/> Lose Weight
<input type="checkbox"/> Reduce Stress	<input type="checkbox"/> Increase Muscular Size	<input type="checkbox"/> Muscular Strength	<input type="checkbox"/> Reduce Back Pain
<input type="checkbox"/> Other			

#### Your Commitment

How many days per week will you <i>realistically</i> commit to exercise?	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> ≥5
How many minutes per exercise session will you <i>realistically</i> commit?	<input type="checkbox"/> 15	<input type="checkbox"/> 15-30	<input type="checkbox"/> 30-45	<input type="checkbox"/> ≥45

#### Nutrition and Weight Loss

	Yes	No
Would you like to lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much weight would you like to lose?		
Have you ever been on a diet or been involved with diet programs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever purposely restricted food intake and obtained what you or others felt was an extremely low or unhealthy weight?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever thrown up, used laxatives, or exercised for extremely long periods to try to lose weight?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take vitamin or mineral supplements?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please list type and amounts:		
Are you currently on a special diet for medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain:		
If no, have you ever been on a special diet and for what reason (i.e, vegetarian, high protein, etc.)?		

#### The following lifestyle questions are optional

	Yes	No	
<b>Tobacco Use</b>			
Do you use cigarettes, cigars or other tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how many uses per day?
Are you a former tobacco user?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, when did you quit?
How many years have you been using tobacco or did you use tobacco before you quit?			
Which type(s) of tobacco products did/do you use?			<input type="checkbox"/> cigarettes <input type="checkbox"/> pipe <input type="checkbox"/> cigar <input type="checkbox"/> other

#### Please rate your average daily stress level.

Low     Moderate     High, positive     High, sometimes difficult     High, often difficult

**How many servings of alcohol do you consume per week?**

**Please continue on the next page.**



# Your WellPoint Wellness Program Health Coaching Membership Application

## WAIVER, RELEASE OF LIABILITY, AND CONSENT TO MEDICAL ATTENTION

**Identification of Risks:** I understand that participation in the Health YOUUniversity and its programs (hereafter referred to as the “Programs”) may involve risk of injury, disability and death, and perhaps damage to property. I also understand that my participation is completely voluntary and is not a term or condition of my employment.

**Obligation to Inspect Facilities and Equipment:** I agree that prior to participating in the Programs, I will inspect the facilities and equipment to be used. If I believe anything to be unsafe, I will immediately advise the National Institute for Fitness and Sport (NIFS) of such unsafe conditions and may decline to participate in the Programs.

**Assumption of Risk:** I understand that before beginning or changing any exercise program, it might be recommended that I consult with my physician. I am physically and psychologically ready to participate in the Programs and assume all risks connected with my participation in the Programs. I accept personal responsibility for any liability, injury, loss or damage in any way connected with my participation in the Programs.

**Waiver and Release of Liability:** I release and discharge WellPoint, Inc. and NIFS, and each of their affiliated or subsidiary organizations, directors, officers, sponsors, employees, agents, successors, and assigns from all claims for any liability, injury, loss, or damage in any way connected with my participation in the Programs, whether or not caused in whole or part by the negligence of any organizations or individuals mentioned above. I declare that I am a voluntary participant in the employer’s sponsored recreation activities and Programs and hereby waive and relinquish all rights to worker’s compensation benefits for any injury or disability incurred while participating in such activities or Programs. I intend for this waiver and release to also apply to my relatives, personal representatives, heirs, beneficiaries, next of kin, and assigns who might pursue any legal action or claim for such liability, injury, loss or damage. This waiver and release nullifies any prior waiver and release signed by me.

**Consent to Medical Treatment:** I agree that WellPoint, Inc. and NIFS (including their affiliated and subsidiary organizations, directors, officers, sponsors, agents, successors, and assigns) may, but have no duty to provide me, through medical personnel of their choice, customary medical or training assistance, transportation, and emergency medical services.

Membership in the facilities is a privilege and may be revoked for failure to comply with facility rules or improper or abusive conduct. For your health and safety, a physician’s consent form may be required prior to membership acceptance and/or wellness related services.

**I have read this waiver, release, and consent and understand that I have given up substantial rights by signing it. I am signing this waiver, release and consent voluntarily. To the best of my knowledge, the information I have provided is accurate. I will agree to inform the Health YOUUniversity staff of any changes in my health status.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Business phone

\_\_\_\_\_  
Mail point

**Reviewer Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

