Saline Heart Wellness Center

Fit for Health Participant Information

Account # _____
Date _____

Last Name: _____ First Name: _____ Middle Initial: _____
Cell Phone #: _____ Home Phone #: _____
Email Address: _____
Mailing Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
☐ Physical address is the same as mailing address
Physical Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Social Security #: _____
Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Spouse's Name: _____ Phone #: _____
Spouse's Employer: _____ Work Phone #: _____

Education: ☐ High School ☐ Associate Degree ☐ College ☐ Post Graduate
Race: ☐ Caucasian/White ☐ Black American ☐ American Indian ☐ Asian
Ethnic Group: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino
Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other _____

Primary Care Physician: _____
Pharmacy Name and Location: _____

Employer Information

Occupation: _____
Employer: _____ Work Phone #: _____

In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Saline Heart Wellness Center

Fit for Health Payment Notice

Saline Heart Wellness Center is offering a lifestyle weight loss program on a cash only basis. There are 4 programs to choose from which are non-refundable, and full payment is due prior to participation. Packages range from $75.00 to $500.00.

Some insurance plans may or may not cover portions of our programs; however, we are offering our services on a cash only basis. No services are filed out to insurance.

In electing to participate in our program your payment will not be credited toward any copays, deductibles, or co-insurances on any portion of our program that may be covered by your insurance.

I have read this election to self-pay for services and have had the opportunity to ask any questions about the programs and policies. Any questions I may have had about this form have been answered to my satisfaction. I have freely chosen to self-pay and participate in the lifestyle weight loss program.

Participant's Name: _____

Participant's Signature: _____

Date: _____

Saline Heart Wellness Center

Fit for Health Participant Questionnaire

Participant Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Age: _____ Occupation: _____

Allergies:

Are you allergic to iodine, seafood, or radiographic contrast dye? Yes ☐ No ☐

Please list ANY other allergies and describe the reaction:

Allergy to:	**Reaction:**
_____	_____
_____	_____
_____	_____

Current Medications:

Remember to bring all medications with you at time of appointment

Please list all medications (prescription and non-prescription) that you are currently taking:

Medication Name	**Dosage**	**How Often Taken?**	**Who Prescribed?**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History:

Please check if you have had any of the following problems in the past:

_____ Cardiac arrest
_____ Heart attack
_____ Congestive heart failure
_____ Abnormal EKG
_____ Palpitations, skips, or irregular heartbeat
_____ Abnormal heart rhythms
_____ Chest pain, pressure, or tightness
_____ Pain in the arms, throat, jaw, or upper back
_____ Heart valve disease
_____ High blood pressure
_____ Infection in the heart
_____ Stroke
_____ Blackouts or fainting spells
_____ Frequent dizzy spells
_____ Diabetes
_____ Kidney disease
_____ COPD
_____ Sleep apnea or other problems sleeping
_____ CPAP
_____ Blood clots in veins or legs
_____ Blood clots in lungs

Past Surgeries:

Please provide the year for all that apply:

_____ Gallbladder _____ Hernia _____ Appendix _____ Hysterectomy
_____ Tonsillectomy _____ Prostate _____ Breast biopsy or mastectomy
_____ Other: _____

Past Medical Illness:

Please list any serious illness for which you have been hospitalized (except admissions for surgery):

_____ _____

_____ _____

Social History and Lifestyle:

Do you drink alcohol? Yes ☐ No ☐ If Yes, how often? _____

Do you currently smoke? Yes ☐ No ☐ If Yes, how often? _____

How many years have you been smoking? _____ How many packs a day? _____

If you quit smoking, when did you quit? _____ How many years did you smoke before quitting? _____

Are you on a special diet? Yes ☐ No ☐ If Yes, what type of diet? _____

How many cups of caffeinated beverages do you drink on an average day? _____

Do you have a history of drug dependency? Yes ☐ No ☐ If Yes, specify: _____

Exercise:

1. Do you exercise regularly? Yes ☐ No ☐
2. If yes, what type of exercise? (check all that apply) Cardio ☐ Strength ☐ Flexibility ☐ Balance ☐
3. Of the types of exercises you checked, please briefly describe what specific exercises you do:

   Cardio: _____

   Strength: _____

   Flexibility: _____

   Balance: _____
4. How often do you exercise each week? 1-2 days ☐ 3-4 days ☐ 5 days or more ☐
5. How long do you exercise each day? 10-20 minutes ☐ 20-30 minutes ☐ 30 minutes or more ☐

Additional Comments: _____

Nutrition:

How many snacks or meals do you eat each day? Meals: _____ Snacks: _____

Do you eat out? Yes ☐ No ☐

If so, how many days per week? 0-1 day ☐ 2-4 days ☐ 5-7 days ☐

What types of places do you visit when eating out? Fast food ☐ Restaurant ☐ Diner/Cafeteria ☐ Other ☐

How many days per week do you consume vegetables? 0-1 day ☐ 2-4 days ☐ 5-7 days ☐

How many days per week do you eat red meat (beef, lamb, veal) or pork? 0-1 day ☐ 2-4 days ☐ 5-7 days ☐

How many days per week do you eat chicken or turkey? 0-1 day ☐ 2-4 days ☐ 5-7 days ☐

How many days per week do you eat fish or shellfish? 0-1 day ☐ 2-4 days ☐ 5-7 days ☐

How many hours of TV do you watch each day? None ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7+ ☐

Do you usually snack while watching TV? Yes ☐ No ☐

What types of beverages do you usually drink, and how many servings of each do you drink in an average day?

Water ☐_____ Juice ☐_____ Soda ☐_____ Diet Soda ☐_____ Sports Drinks ☐_____ Iced Tea ☐_____

Sweet Tea ☐_____ Milk ☐_____ Beer ☐_____ Wine ☐_____ Hard Liquor ☐_____

Additional Comments: _____

Participant signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____