HEALTHY LIVING PROGRAM
NEW PARTICIPANT HEALTH HISTORY
CAREGIVER

Wellness House for LIVING with CANCER
You'll feel better inside.

NEW PARTICIPANT INFORMATION

Name _____ Date _____/_____/_____

Phone _____ Email _____ Date of Birth _____/_____/_____

Emergency Contact Name _____ Relationship to you _____

Phone Numbers: Home _____ Work _____ Cell _____

Primary care physician: _____ Date of last visit: _____/_____/_____

Other Specialist: _____ Date of last visit: _____/_____/_____

MEDICAL HISTORY

1. Check ALL spaces below that apply to you. (Please include explanation and date of occurrence.)

Present Medical History	Explain and Date	Present Medical History	Explain and Date
☐ Rheumatic fever/heart murmur		☐ Foot/ankle problems	
☐ Chest discomfort		☐ Knee/hip problems	
☐ Heart abnormalities, racing/skipping beats		☐ Thyroid problems	
☐ Abnormal ECG		☐ Lung disease	
☐ Coughing up blood		☐ Chronic/recurrent cough	
☐ Stomach/intestinal problems		☐ Disease of arteries	
☐ Anemia		☐ Varicose veins	
☐ Stroke		☐ Arthritis	
☐ Migraine/recurrent headaches		☐ Epilepsy	
☐ Back/neck pain/injuries		☐ Vision/hearing problems	

2. Hospitalizations and Operations (starting with the most recent)
   1. _____ Date: ____/____/____
   2. _____ Date: ____/____/____
   3. _____ Date: ____/____/____
   4. _____ Date: ____/____/____

MEDICATION LIST

Medication	Prescribed for	Dosage	Date started

CARDIOVASCULAR RISK STRATIFICATION

Please check the appropriate box, if you have experienced any of the following:

☐ Heart attack	☐ Coronary angioplasty (PTCA)	☐ Heart transplantation
☐ Heart surgery	☐ Heart valve disease	☐ Congenital heart disease
☐ Cardiac catheterization	☐ Heart failure	
☐ Pacemaker/implantable cardiac defibrillator/rhythm disturbance		
☐ You experience chest discomfort with exertion		☐ You experience dizziness, fainting or blackouts
☐ You experience unreasonable breathlessness		☐ You take heart medication
☐ You have diabetes		☐ You have concerns about the safety of exercise
☐ You have asthma or other lung disease		☐ You take prescription medications
☐ You have burning or cramping sensation in your lower legs when walking short distances		
☐ You have musculoskeletal problems that limit your physical activity		
☐ You are pregnant		
☐ You are a man older than 45 years		☐ You are > 20 pounds overweight
☐ You are a woman older than 55 years, have had a hysterectomy, or are postmenopausal		
☐ You smoke, or quit smoking in the previous 6 months		☐ You take blood pressure medication
☐ Your blood cholesterol level is > 200 mg/dL		☐ You do not know your cholesterol level
☐ You have a blood relative who had a heart attack or heart surgery before age 55 (father/brother) or age 65 (mother/sister)		
☐ You are physically inactive (i.e., you get < 30 minutes of physical activity on at least 3 days/week)		
☐ **NONE OF THE ABOVE**		

LIFESTYLE & ACTIVITY EVALUATION

Daily Activity Analysis

1. How many days per week do you exercise regularly? _____
2. What exercises do you participate in regularly? _____
3. How many minutes do you spend exercising at one time? _____
4. Would you consider your exercise to be (check one): ☐ light ☐ moderate ☐ vigorous
5. What physical activities are the most enjoyable to you? _____
6. Has your physical activity changed in the past year? _____
7. What is your main goal related to starting an exercise program? _____

   _____
8. Do you anticipate any barriers to starting an exercise program?

   ☐ Lack of time ☐ Lack of enjoyment from exercise ☐ Fatigue or feeling unwell

   ☐ Lack of self-discipline ☐ Lack of equipment ☐ Weather

   ☐ Other (specify): _____

EXERCISE PROGRAM & WELLNESS TUNE-UPS
PARTICIPANT INFORMED CONSENT WAIVER

We request your understanding and cooperation in maintaining both your and our safety and health by reading and following this informed consent agreement. **Please print your name in each box and sign at the bottom.**

EXERCISE PROGRAM & MIND BODY MOVEMENT CLASSES

I, *(print name)* _____ declare that I intend to participate in the Wellness House Exercise Program such as exercise classes, exercise consultations, fitness assessments and/or Mind Body Movement classes.

I understand there is risk in participating in the Wellness House Exercise Program and Mind Body Movement classes relative to my own state of fitness and health (physical, mental and emotional) and to the awareness, care and skill with which I conduct myself. I acknowledge that my choice as a participant brings with it my assumption of those risks or results stemming from my choices, fitness, health, awareness, care and skill.

I understand each person, me included, has a varied capacity for participating in such activities, facilities, programs and services and I am aware that these are educational, recreational or self-directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I further understand that personnel: certified, registered, licensed or otherwise at times conduct the activities. I accept this fact and that no claim is made to offer assessment or treatment by those who are certified, registered, licensed or otherwise.

I recognize that I may experience potential health risks such as transient lightheadedness, fainting, abnormal blood pressure, chest discomfort, muscular cramps and nausea. I assume willfully risks that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity. I may also be requested to stop and/or rest by a facilitator who observes any symptoms of distress or inappropriate response. I understand that I may ask any questions or request further explanation of information at any time before, during or after my participation.

WELLNESS TUNE-UPS

I, *(print name)* _____ declare that I intend to participate in Wellness House Wellness Tune-ups such as Massage, Oncology Facial Massage, Craniosacral Therapy, Reiki, Healing Touch & Energy Touch.

I understand that Massage, Oncology Facial Massage & Craniosacral Therapy involve a variety of manual techniques that manipulate the muscles, soft tissues and/or cranial sacral system intended for stress reduction and relaxation. I also understand that Reiki, Healing Touch & Energy Touch are simple, gentle, hands-on energy techniques used for stress reduction and relaxation.

I further understand and acknowledge that in no way are these services meant to be construed by me as the diagnosis or treatment of disease, but rather as an aid for stress reduction and relaxation.

I understand that prior to my first session, I will receive an oral explanation and description of the service I will receive. I understand that I may refuse any and all services at any time. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

In further consideration of being permitted to participate in Exercise, Wellness Tune-ups and/or Mind Body Movement classes, I knowingly, voluntarily and expressly waive any claim I may have against Wellness House, its administration, class facilitators and/or volunteers for any injury or damages that I may sustain as a result of participating in the program.

I, my heirs or legal representatives, forever release, waive, discharge and covenant negligence or other acts.

I understand that I may ask any questions or request further explanation of information about the activities, facilities and Wellness House programs and services at any time before, during or after my participation.

I understand that these services are not a substitute for medical treatment or medications, and it is recommended that I concurrently work with my physician or primary caregiver for any condition that I may have.

I have read the above release and waiver of liability and fully understand its content. I voluntarily agree to the terms and conditions stated above.

Signature_____ Date _____/_____/_____

☐ I am under 18 yrs old, **Parent Signature** _____ Date _____/_____/_____