HEALTHWAYS

Healthways SilverSneakers Fitness Program

Place Healthways swipe card sticker here

OR write the ID assigned by your computer system for tracking this member's activity

Getting to Know You - 2010

18603 - The Ursuline Center

Print in blue or black ink, one character per box.
***Complete exactly as printed on Health Plan Card.**

A	B		1

18603

*** Health Plan / Insurance Company Name**

Today's Date Month / Day / Year

*** Health Plan / Insurance Member ID**

*** Last Name**

*** First Name**

MI

Address

City

State

Zip Code

Telephone Area Code - -

Gender M/F

Date of Birth Month / Day / Year

E-mail Address

Confidential

A.C.T. Now for Fitness!

Assess Your Fitness

Member Information

Height: ☐ **Feet** ☐☐ **Inches** **Weight:** ☐☐☐ **Pounds**

Fitness Assessment

Fill in bubbles completely. ●

	Excellent	Very Good	Good	Fair	Poor
In general, how would you rate your health?	○	○	○	○	○

How many days per week would you say that you currently:	# of Days Per Week 0	1	2	3	4	5+
Attain 30 minutes or more of moderately intense aerobic exercise (such as brisk walking)	○	○	○	○	○	○
Lift weights or participate in some form of muscular strengthening activity	○	○	○	○	○	○
Do stretching or participate in flexibility exercises (such as Yoga)	○	○	○	○	○	○

Choose Your Fitness Goals

Please choose your current fitness goal(s) from the following list (select all that apply):

- ○ Improve my cardiovascular endurance
- ○ Increase muscle strength and conditioning
- ○ Increase flexibility, balance and prevent falls
- ○ Exercise three (3) or more times per week
- ○ Maintain or achieve a healthy weight

Track Your Progress

	Mailed to my home	Via e-mail
Depending on your health plan, you may receive personal progress reports. How would you like to receive your copy?	○	○

Activity Readiness Assessment - 2010

Please read and consider the following list of conditions. To protect your privacy, please DO NOT WRITE anything next to them:

- Chest pains while at rest and/or during exertion
- Previous heart attack
- High blood pressure
- Diabetes
- Frequent fast, irregular heartbeats OR very slow heartbeats
- Previous hip or spinal fracture (as an adult)
- Shortness of breath after mild exertion, at rest, or in bed
- Open cuts on your feet that do not seem to heal
- An unexplained weight loss of ten (10) pounds or more in the past six (6) months
- Any heart or circulatory conditions, such as vascular disease, stroke, chest pain, congestive heart failure, poor circulation to the legs, valvular heart disease, blood clots
- Lung disease
- More than two falls in the past year (no matter what the reason)
- More than one year since you have engaged in regular physical activity

1. Is your physician unaware of any of the above conditions?

Check One ☐ Yes ☐ No

2. Has your physician recommended any limitations to your physical activity?

Check One ☐ Yes ☐ No

Please sign that you understand the above questions and have completed this assessment. Ask your Senior Advisor if you have any questions or concerns.

Name (Please print): _____

Signature: _____ Today's date: _____

Note:
You may be asked to obtain a signed Release for Activity or a note from your health care provider allowing you to participate before starting the program. If you are not asked to obtain a release, you are cleared to begin a gradual program of regular exercise.

Physical Activity Waiver - 2010

I acknowledge that I have voluntarily chosen to participate in a program of progressive physical exercise. I acknowledge that the strenuous nature of the program and the risks associated with my participation in the program have been explained to me, including, but not limited to, risks of physical injury, abnormal blood pressure, heart attack and death; and risks associated with the negligence of a Healthways participating location and any other organization participating or involved in providing or promoting any classes, functions, programs, testing, or other activities that I participate in at a Healthways location (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing).

By signing this document, I expressly assume all risk for my health and well-being and expressly assume the other risks associated with participating in the program, including, but not limited to, the negligence of a Healthways participating location and any other organization participating or involved in providing or promoting any classes, functions, programs, testing, or other activities that I participate in at a participating location (including without limitation the owners, officers, directors, employees, and representatives of the foregoing). I also hereby release, waive, discharge and covenant not to sue a class instructor, a Healthways participating location, any sponsoring organization, Healthways, Inc., or any of its subsidiaries or any other organization providing or promoting classes, functions, programs, testing, or other activities that I participated in at a Healthways location (including without limitation the owners, officers, directors, employees, and representatives of any of the foregoing) at any time hereafter, from any and all demands, liabilities, losses, or damages (including death or damage to property) caused or alleged to be caused in whole or in part by the negligence of any of the foregoing people or entities.

I have read, understand, had explained to me, and had the opportunity to ask questions concerning this waiver, release, and express assumption of risk. I have also read, understand, and will adhere to all guidelines and policies in regard to this benefit. This waiver and release shall survive the term of any agreement with a Healthways participating location.

Print Member's Name

Member's Signature | Date

Emergency Contact Name | Contact Phone Number

Participating Location Name and Staff Signature | Date

(Version 2010)

Release for Activity - 2010

(Member's Name) _____ wishes to participate in exercise and/or fitness activities and has been referred to a physician for an activity release.

Healthways offers physical activity benefits to member groups through fitness center networks in your area. The member may use amenities such as exercise equipment, swimming pools and may also participate in strength and conditioning classes designed for older adults which can be completed from a seated position.

Specific comments regarding limitations or contraindications for activity:

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_____ _____

Physician or Licensed Practitioner Signature Date

You may mail or fax this completed form to the participating location, Attn: Senior Advisor.

For Site Use Only

The Ursuline Center - 18603
4280 Shields Rd.
Canfield, OH 44406
Phone: (330) 799-4941
Fax: (330) 799-4988

_____
Staff Signature