

Wellness on Wheels Intake Form

Please circle "Yes" for any items that pertain to you:

- I participate in Healthtrac Rewards.....Yes
- A Wellness staff member may contact me for a follow-up.....Yes
- I have a family history of heart disease before age 50.....Yes
- I use tobacco.....Yes
- I have diabetes.....Yes
- I have bone/joint limitations.....Yes
- I am pregnant/breastfeeding.....Yes
- I engage in at least 30 minutes of moderate level Physical Activity 5 days a week OR
20 minutes of vigorous physical activity 3 days a week.....Yes
- I am on medication that affects a condition below.....Yes
 o If "Yes", please circle affected condition(s):
 Cholesterol Triglycerides Diabetes Blood pressure Anxiety/Depression GERD
- I am concerned about my prescription costs.....Yes

For each area of health listed below, check the box that best indicates your current status.

	<u>Not Applicable</u> or I do not believe I need improvement in this area	<u>I have been</u> taking action in this area for the past 6 months	<u>I am currently</u> taking action in this area	<u>I am thinking about</u> taking action in this area within the next 6 months	<u>I do not plan</u> to take action in this area within the next 6 months
Eating habits					
Weight loss					
Physical activity					
Tobacco use					

Name: _____ Last 4 #s of SSN: _____ Age: _____ Date: _____

Office Use Only -

Height: _____ in.

Weight: _____ lbs.

BMI _____

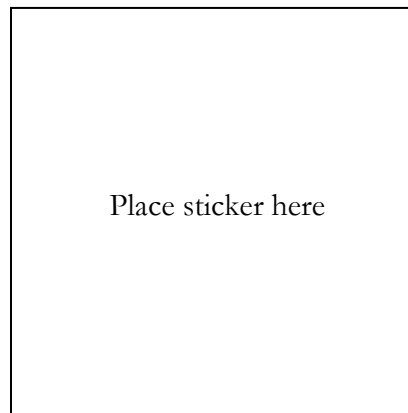
Body Fat % _____

Waist Circumference: _____ in

BP: _____ mmHg

RHR: _____ bpm

Fasting? Yes No



BW: _____

Out: _____

Program(s): _____

Handout(s): _____

Additional info: _____