



PARTICIPANT REGISTRATION

Bald Head Island Center for Wellness, LLC
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Please complete this form as thoroughly as possible. Please sign and either mail or fax this form to the address listed above. All information is strictly confidential.

Your First Name: _____ Your Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Telephone (mobile): (____) - _____

Personal Information

To assist us with customizing your individual wellness program, please answer the following questions with as much detail as possible.

Date of Birth (MM/DD/YYYY): _____ Height: _____

Weight: _____ BMI Index: _____ (To Calculate your BMI: www.nhlbisupport.com/bmi/)

Occupation: _____ Employer: _____

Sex: _____ Marital Status: _____ Dress size (women) _____

Pant size: _____ Shoe size: _____

What do you consider a healthy weight for yourself? _____

Do you exercise? ___ Yes ___ No

If "Yes", what type of exercise do you perform? _____



How often do you exercise? _____

How long have you been adhering to this exercise routine?

_____ months _____ years

Do you have any physical or medical limitations that would hinder physical activity or an exercise program? ___ Yes ___ No

If "Yes", please explain: _____

Has your physician advised you **not** to do certain activities?

Do you have any medical issues that you feel we should be aware of?

What medications (including over-the-counter) are you currently taking, If any?

Do you have any drug or food allergies? ___ Yes ___ No

If "Yes", what are they? _____

Do you have any special dietary need or expectations?

The name of your personal physician:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Telephone: (____) - _____



In case of emergency, please contact:

Name: _____ Telephone: (____) - _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____ Telephone (mobile): (____) - _____

Your responses results to the following questions will determine if we should contact your physician prior to attending the program.

- PAR-Q (Physical Readiness – Questionnaire)
- Physician Referral Form
- Risk Factor Evaluation – Please check if any of the following apply to you:
 - High blood pressure (greater than 140/90)
 - High blood cholesterol (greater than 240mg/dl)
 - Cigarette smoker
 - Diabetic (Type 1 or Type 2)
 - Family history of coronary heart disease and/ or stroke (prior to age 55)

To help you achieve your health goals, we ask that you provide us with the following information. All information will remain confidential.

What motivated you to contact us about the program?

What **nutrition** information do you wish to obtain?



Are you currently on a diet? Yes No

If "Yes", what kind of diet? (example: low fat, low calorie, low carbohydrate)

How ready are you to change your eating habits? (Please circle one)

Not Ready.....Somewhat Ready.....Very Ready

What information on **exercise** do you wish to learn?

What exercise equipment do you own?

What exercise facilities do you have access to?

How ready are you to start an exercise program? (Please circle one)

Not Ready.....Somewhat Ready.....Very Ready

What information about **stress** do you wish to receive?

Do you practice any stress reduction techniques? Yes No

If "Yes", what techniques do you regularly practice?

Are you ready to better manage your stress? (Please circle one)

Not Ready.....Somewhat Ready.....Very Ready



Referral Information

Have you ever been to another health program, wellness center or spa?

Yes No

If "Yes", which one(s)?

Have you considered attending other wellness/diet programs prior to selecting our wellness center? _____

What was your deciding factor for selecting the BHI Wellness Center?

Do you have any additional questions we can answer for you ?

Thank you for taking the time to complete this registration form