

Membership & Medical Form for AgeWell Services



Please complete the following information. All information is **confidential**.

Name:		Phone:	()
Address:	City:		
State:	Zip:	Birth Date * (required)	

Emergency Contact Information

Contact Name:		Phone:	()
Relationship to you:			
Physician's Name:		Phone:	()
Hospital Preference:		Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Supplemental Insurance Contract No.:		Group No.:	

List Medications Currently Taken & Dosage: (use back of page if needed)

List Medication Allergies:

List Food Allergies:

List Special Health Information including chronic illnesses, surgeries, etc.:

I understand that this information will be used in emergency situations **only** as a means to provide me with proper care in case of illness or accident. I understand that all expenses incurred in an emergency situation are my responsibility and not that of AgeWell Services and that it is my responsibility to update this form as changes in my information occur.

I understand that this information is considered **very** confidential and will not be used for any supplementary purposes. I **authorize/ do not authorize (Circle one)** AgeWell Services to utilize any photographs, personal narrative, interviews or audio and video recording of my participation in any AgeWell event for any and all purposes to help promote the program.

E-Mail Address: (optional)	Enclosed Check Amt: \$
Signature:	Date:

****This form is required to participate in AgeWell activities.***

These clubs are being started by and for people over 50 who have an interest in the following areas. They will be the kind of groups that you create! We supply the place to come together; you supply the leadership and ideas.

<u>Free Clubs (except supplies)</u>	<u>Would like to lead:</u>	<u>Help lead:</u>
<input type="checkbox"/> Antique	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Armchair Travel	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Beading (Jewelry)	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Book	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Bridge	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Chess	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Cribbage	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Current Events	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Genealogy	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Photography	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
(Sharing pictures, discussions, etc.-- NO DARK ROOM)		
<input type="checkbox"/> Quilting, & other embroidery	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Scrapbooking	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Stamps	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Table Tennis	<input type="checkbox"/> Lead	<input type="checkbox"/> Help
<input type="checkbox"/> Walking/ Hiking	<input type="checkbox"/> Lead	<input type="checkbox"/> Help

FUTURE CLASSES. (Check any...)

<u>Interested?</u>	<u>I can help/lead:</u>
<input type="checkbox"/> Autobiography	<input type="checkbox"/>
<input type="checkbox"/> Ballroom Dance	<input type="checkbox"/>
<input type="checkbox"/> Band/Orchestra	<input type="checkbox"/>
<input type="checkbox"/> Bell ringers	<input type="checkbox"/>
<input type="checkbox"/> Belly Dance	<input type="checkbox"/>
<input type="checkbox"/> Fly Tying for Men	<input type="checkbox"/>
<input type="checkbox"/> Book Author	<input type="checkbox"/>
<input type="checkbox"/> Boot Camp	<input type="checkbox"/>
<input type="checkbox"/> Bunko	<input type="checkbox"/>
<input type="checkbox"/> Candle making	<input type="checkbox"/>
<input type="checkbox"/> Computer-How to e-bay	<input type="checkbox"/>
<input type="checkbox"/> Cycling	<input type="checkbox"/>
<input type="checkbox"/> Drama	<input type="checkbox"/>
<input type="checkbox"/> Eye Glass Ornaments	<input type="checkbox"/>
<input type="checkbox"/> Foreign Language	<input type="checkbox"/>
<input type="checkbox"/> Gardening Classes	<input type="checkbox"/>
<input type="checkbox"/> Guitar	<input type="checkbox"/>
<input type="checkbox"/> Harmonica	<input type="checkbox"/>
<input type="checkbox"/> Health Insurance	<input type="checkbox"/>
<input type="checkbox"/> Investments	<input type="checkbox"/>
<input type="checkbox"/> Jazz Dance	<input type="checkbox"/>
<input type="checkbox"/> Journaling	<input type="checkbox"/>
<input type="checkbox"/> Juice harp	<input type="checkbox"/>
<input type="checkbox"/> Kayaking	<input type="checkbox"/>
<input type="checkbox"/> Kitchen Band	<input type="checkbox"/>

<u>Interested?</u>	<u>I can help/lead:</u>
<input type="checkbox"/> Legal services	<input type="checkbox"/>
<input type="checkbox"/> Lunch Box Social	<input type="checkbox"/>
<input type="checkbox"/> Making Greeting Cards	<input type="checkbox"/>
<input type="checkbox"/> Music Appreciation	<input type="checkbox"/>
<input type="checkbox"/> Music Literacy	<input type="checkbox"/>
<input type="checkbox"/> Neurobics	<input type="checkbox"/>
<input type="checkbox"/> Nordic Walking	<input type="checkbox"/>
<input type="checkbox"/> Oil Painting	<input type="checkbox"/>
<input type="checkbox"/> One Stroke Painting	<input type="checkbox"/>
<input type="checkbox"/> Origami	<input type="checkbox"/>
<input type="checkbox"/> Osteoporosis Ball	<input type="checkbox"/>
<input type="checkbox"/> Paper Cutting (Scherenschnitte)	<input type="checkbox"/>
<input type="checkbox"/> Piano	<input type="checkbox"/>
<input type="checkbox"/> Readers Theatre	<input type="checkbox"/>
<input type="checkbox"/> Reverse mortgages	<input type="checkbox"/>
<input type="checkbox"/> Snowshoeing	<input type="checkbox"/>
<input type="checkbox"/> Spoons	<input type="checkbox"/>
<input type="checkbox"/> Stretching & Foot Massage	<input type="checkbox"/>
<input type="checkbox"/> Swing Dance	<input type="checkbox"/>
<input type="checkbox"/> Tae Kwon Do	<input type="checkbox"/>
<input type="checkbox"/> Tap Dancing	<input type="checkbox"/>
<input type="checkbox"/> Woodworking	<input type="checkbox"/>
<input type="checkbox"/> Writing Class	<input type="checkbox"/>
<input type="checkbox"/> OTHER _____	<input type="checkbox"/>
<input type="checkbox"/> OTHER _____	<input type="checkbox"/>

Health Pre-Screening - You fill in this area

- | | | |
|-----|----|--|
| Yes | No | 1. Have you ever had, or has your doctor ever diagnosed you as having heart trouble or coronary heart disease? |
| Yes | No | 2. Do you ever have pains in your chest? |
| Yes | No | 3. Do you have diabetes? |
| Yes | No | 4. Are you a <u>male</u> 45 years or older? <u>Female</u> 55 years or older |
| Yes | No | 5. Do you have a history of high blood pressure? |
| Yes | No | 6. Do you smoke cigarettes? |
| Yes | No | 7. Do you have elevated cholesterol? (Greater than 200 total or less than 35 HDL) |
| Yes | No | 8. Have any of your blood relatives had heart disease, heart surgery, or angina? |
| Yes | No | 9. Are you sedentary? (a couch potato) |
| Yes | No | 10. Are you over 20% ideal bodyweight? |
| Yes | No | 11. Are you taking any meds for high blood pressure? |
| Yes | No | 12. Has your physician advised you to exercise? |
| Yes | No | 13. Do you have any difficulty with physical exercise? |
| Yes | No | 14. Do you participate in any recreational activities? (___golf, ___tennis. ___biking _____ other) |
| Yes | No | 15. Do you start an exercise program <i>but find yourself unable to stick with it?</i> |
| | | 16. What do you consider the most likely reason for you not sticking to your exercise program? ___Limited time ___Lack of results ___Lack of motivation ___Dislike exercise ___Unsure of what to do ___Other |

Special Considerations:

Please check any condition you now have or have had in the past.

___ Low blood pressure: _____ Lung Disease: _____

___ Hypoglycemia: _____ Hearing impaired: _____

___ Asthma: _____ Dizziness: _____

___ Hernia: _____ Osteoporosis: _____

___ Arthritis (rheum/osteo) _____ Bursitis or tendonitis: _____

___ Other: _____

Problems with: ___ Knee: _____

___ Shoulder: _____

___ Back: _____

___ Neck: _____

___ Hip: _____

***Fitness Specialist will fill in this area while testing you**

HEALTH PRE-SCREENING - Readiness (continued)			Date:	
	Your Info.	Below Average	Average	Above Average
Name				
Date of Birth				
Height				
Weight				
BMI (Body Mass Index)				
Body Fat Percentage %				
Heart Rate - Resting:				
Take meds? Yes/No - Target:				
Blood Pressure Check				
Measurements - Chest				
Waist				
Hips				
Fitness Challenges!				
Cardio - March in place				
Strength - Bicep Curls				
Flexibility - Sit & Reach				
Orientation to Fitness Room?				
Yes No, not now	Date:	You must have this orientation in order		
	Time:	to use the Fitness equipment.		