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Your Wellness Institute Membership

We would like to take this opportunity to welcome you as a new member of the Wellness Institute at Seven Oaks General Hospital.

As we indicated when you applied to become a member, we will need you to sign the Membership Application. If you are under 18 years of age, your parent or guardian must sign the Membership Application as well.

By signing the Membership Application, you will be entering into a contract with the Wellness Institute in which you will be bound by the terms and conditions found in the Member Handbook and the Membership Application.

Please read your Member Handbook and Membership Application carefully to ensure that you agree with all of the terms and conditions contained in it.

If, after reading the Member Handbook, you do not agree to the terms and conditions contained in any of these documents, please inform us so that we may refund your prorated membership fee (less the enrollment fee).

Should you have any questions, please do not hesitate to contact us.

Thank you again for joining the Wellness Institute. We look forward to seeing you in the coming days, weeks and years!

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Health Screening Process

You have made an important commitment to your health and wellness. We encourage you to take part in our New Member Health Screening process which allows us to accurately assess your health risks and develop a personal exercise and wellness plan for you.

The process begins by completing the Health Risk Assessment to identify any health risks, injuries and medical concerns you may have. Based on your answers, we will suggest that you participate in one or more of the following appointments:

- Personal Wellness Plan
- Graded Exercise Test (Stress Test)
- Assessment with Physiotherapist
- Spirometry Test with Respiratory Therapist

Our team of health professionals will use this information to develop a safe and effective exercise and wellness plan that will help you achieve your fitness and wellness goals.

Personal health information will be collected and may be used for research, quality improvement and evaluation initiatives. This information will be collected, linked with other datasets, and stored in accordance with the laws on privacy and data collection. All data access requests and linkages must be reviewed and approved by the Seven Oaks Hospital Research Director and appropriate review boards. Only aggregate, de-identified data will be presented in research or evaluation reports.

Degreed Wellness Consultants are available throughout the facility during your visit. Ask questions any time if you have a change in your health and wellness goals, need help with the equipment or an updated exercise plan. They are here to support you in reaching your health and wellness goals.

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Health Risk Assessment

Name: .... DOB: .... Gender: ....

PHIN: ....

Part 1

A.

		Yes	No
1.	Has a doctor ever told you that you have heart disease (heart attack, heart bypass surgery, cardiac catheterization, coronary angioplasty, valve disease repair, congestive heart failure, angina, congenital heart disease)?	☐	☐
2.	Has a doctor ever told you that you have diabetes or renal disease?	☐	☐
3.	Do you have a pacemaker, implantable cardiac defibrillator or a rhythm disturbance?	☐	☐
4.	Have you had a heart transplant?	☐	☐

B.

		Yes	No
5.	Do you feel pain in your chest at rest, during daily activities, or when you do physical activity?	☐	☐
6.	Do you experience unreasonable breathlessness?	☐	☐
7.	Do you experience dizziness, fainting or blackouts?	☐	☐
8.	Do you have ankle swelling?	☐	☐
9.	Do you have burning or cramping sensations in your lower legs when walking short distances?	☐	☐
10.	Do you have an unplesant awareness or a forceful, rapid or irregular heart rate?	☐	☐

Part 2

		Yes	No
11.	Are you a male over 45 years or a female over 55 years?	☐	☐
12.	Does your waist measure more than 40 inches? (Male)	☐	☐
13.	Does your waist measure more than 35 inches? (Female)	☐	☐
14.	Do you smoke or have you smoked in the last six months?	☐	☐

		Yes	No
15.	Do you have high blood pressure or are you being treated for high blood pressure?	☐	☐
16.	Do you have high cholesterol or are you being treated for high cholesterol?	☐	☐
17.	Do you perform at least 30 minutes of moderate intensity activity, minimum of 3 days per week for the last 3 months? (Moderate activities include walking, active gardening, swimming, dancing, biking, etc...)	☐	☐
18.	Were any of your blood relatives (parents or siblings) diagnosed with heart disease or stroke before the age of 55 (male) or 65 (female)?	☐	☐
19.	Do you have or have you ever had high blood sugar or borderline diabetes?	☐	☐

Part 3

		Yes	No	
20.	Do you have:			
a)	A rheumatoid condition?	☐	☐	Describe: ....
b)	A joint, back or neck injury that significantly limits your exercise?	☐	☐	Describe: ....
c)	COPD, Pulmonary Fibrosis or Emphysema that significantly limits your exercise?	☐	☐	Describe: ....
21.	Have you had a:			
a)	Joint replacement within the last year?	☐	☐	Describe: ....
b)	Stroke (excluding TIA)?	☐	☐	
c)	Spinal cord injury?	☐	☐	Describe: ....
d)	Neurological condition?	☐	☐	Describe: ....

Part 4

	Question	Yes	No
22.	Has a doctor ever told you that you have a Lung Disease? (Asthma, Chronic Bronchitis, Emphysema, COPD or Pulmonary Fibrosis)?	☐	☐
23.	Do you cough regularly?	☐	☐
24.	Do you cough up phlegm regularly?	☐	☐
25.	Do you get frequent colds that persist?	☐	☐
26.	Do you become short of breath easily?	☐	☐
27.	Do you wheeze when you exert yourself or at night?	☐	☐

Part 5

28. On average, how many hours of sleep do you get each night?

....

Part 6

Questions refer to most of the time.

	Question	Yes	No
29.	Do you eat at least 3 times per day?	☐	☐
30.	Are vegetables half of your plate at meals?	☐	☐
31.	Do you include lean protein at each meal? (Lean protein examples: poultry, fish, eggs, beans, lentils, chickpeas, yogurt, tofu)	☐	☐
32.	Do you eat red meat once a week or less? (Red meat examples: beef, bison, lamb, goat, pork)	☐	☐
33.	Do you include high-fibre foods at each meal at each meal? (High-fibre food examples: vegetables, fruits, whole grains, beans, lentils)	☐	☐
34.	Do you avoid sugary drinks? (Sugary drink examples: juice, pop, specialty coffee, iced drinks)	☐	☐

35. Do you eat sweets or desserts less than 3 times a week? ☐ ☐

36. Do you eat meals slowly (20 minutes or more) and without distractions (no TV, phone or computer)? ☐ ☐

37. Do you eat out (breakfast, lunch, take-out) less than 3 times per week? ☐ ☐

Part 7

	Yes	No
38. In general, do you usually drink less than 3 drinks of alcohol per day (for men) or less than 2 per day (for women)? (1 drink = 5 oz of wine, 12 oz beer, 1.5 oz spirits)	☐	☐
39. In general, on a single occasion, do you usually drink no more than 4 drinks (for men) or 3 drinks (for women)?	☐	☐

Part 8

40. What medications are you currently taking? ....

....

....

41. Have you had a recent seizure or been diagnosed with seizure disorder? Do you take medication for it?

....

Part 9

42. What are your health and wellness goals? (check all that apply)

❑ Eat Healthy ❑ Quit Smoking ❑ Gain Strength

❑ Increase Endurance ❑ Improve Sport Performance ❑ Lose Weight

❑ Rehab and injury ❑ Other: ....

Readiness to Change Assessment

Part 10

This exercise will help assess your readiness to change behavioural areas related to health and wellness. In the first column, rate how important making behavioural change is to you in each of the relevant areas. In the second column, please rate your current level of confidence in making change in these same areas.

BEHAVIOUR:	IMPORTANCE:	CONFIDENCE:
Increase Exercise		
Improve Nutrition		
Improve Weight Management		
Improve Sleep		
Improve Stress Management		
Reduce / Cease Smoking		

On a scale from 1 – 10 please indicate the importance of change and your current level of confidence in making change" or having a visual scale:

Part 11

The following question will help inform current and future programming and may be used for research purposes.

The Wellness Institute is collecting information about the racial, ethnic, Indigenous identity of individuals we serve. We recognize that this list of racial or ethnic identifiers many not exactly match how you would describe yourself. Keeping that in mind, which of the following best describes the racial or ethnic community that you belong?

- ❑ African
- ❑ Black
- ❑ Filipino
- ❑ Latin America
- ❑ North American Indigenous, First Nations, Metis or Inuit
- ❑ South Asian
- ❑ Southeast Asian
- ❑ White
- ❑ Other
- ❑ Prefer not to answer

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Consent to Participate

Please carefully read the following Consent to Participate. Once you have read the Consent, please initial each of the statements to which you agree and leave blank any statement to which you do not agree. Finally, sign and date the form at the bottom where indicated.

I, ..., (print name) hereby consent to participate in the Health Risk Assessment Screening that may include a stress test and personal wellness plan. I understand that personal health information collected about me will be used to assist the Wellness Institute in developing an individualized wellness plan and to evaluate the Wellness Institute's membership programs. I understand that the information collected about me will be collected, stored, and destroyed in compliance with The Personal Health Information Act of Manitoba (PHIA). If I have any questions or concerns about the collection, storage, or destruction of my personal health information, I understand that I may direct them to the Seven Oaks General Hospital PHIA Officer at (204) 632-3288.

1. I have read and understood the above Consent and agree to participate in the Health Risk Assessment. .... (Initial)
2. I agree to have all medical information and test results forwarded to and/or received from the following physicians: .... (Initial)

    1. Physician: ....
       Address: ....
       ....
    2. Physician: ....
       Address: ....
       ....
    3. Physician: ....
       Address: ....
       ....

3. I agree to have the Wellness Institute at Seven Oaks General Hospital contact me in the future regarding follow up and evaluation. .... (Initial)

Date: .... Members Signature: ....

CERTIFIED MEDICAL FITNESS FACILITY