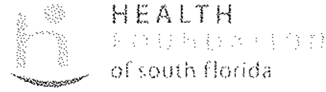

HEALTHY AGING REGIONAL COLLABORATIVE
PARTICIPANT INFORMATION FORM

Class Site: ______________________________ Today's Date: __________________

Section 1

Last Name: ______________________ First Name: __________________________

Middle Initial: ______ Nick Name: ____________ Gender: ☐ Male ☐ Female

Date of Birth: __________ (Month) ______ (Day) __________ (Year) Age: ______________

Address: ____

Unit/Apt #: ______ City: ____________________ State: ______ Zip Code: _________

County: ☐ Broward ☐ Miami-Dade ☐ Monroe

Home Phone: Area Code: (   ) Number: __________________________

Work Phone: Area Code: (   ) Number: __________________________

Cell Phone: Area Code: (   ) Number: __________________________

E-mail: ____

For Staff Only
HARC-G1 Revised 11/04/2008 *DE-Date_____ DE-Initials____*

Section 2

Marital Status:
- ☐ Divorced ☐ Married ☐ Never Married
- ☐ Partnered ☐ Separated ☐ Widowed

Do you have a disability that prevents you from doing activities of daily living without assistance? ☐ Yes ☐ No

Primary Language:
- ☐ Creole ☐ English ☐ Spanish
- ☐ Other (specify) ___________________________

Race: (*check one*)
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ White
- ☐ Two or more races
- ☐ Other Race
- ☐ Prefer Not to Answer

Ethnicities: (*check any that apply*)

Hispanic/Latino
☐ Yes ☐ No

Haitian/ English Caribbean
☐ Yes ☐ No

☐ Prefer Not to Answer

Section 3

Which category below describes your annual personal income?
- ☐ Less than $15,000 ☐ $15,000 to $24,999 ☐ $25,000 to $49,999
- ☐$51,000 to $75,000 ☐ More than $75,000 ☐ Prefer Not to Answer

Do you live by yourself or do you live with other people (*check one*)?
- ☐ Live Alone ☐ Live With One Other Person
- ☐ Live With More than One Other Person (*how many others?*) __________

Section 4

What is the <u>highest</u> level of education that you have completed (*<u>check only one</u>*)?

☐ Never Attended School
☐ Elementary/Grade School
☐ Some High School
☐ High School Graduate
☐ Some College or Vocation School
☐ College Graduate
☐ Master or Doctorate Degree

Section 5

Do you have Medicaid: ☐ Yes ☐ No

Do you have Medicare: ☐ Yes ☐ No

Please check the name of your primary insurance (*check <u>only one</u>*)

☐ Aetna
☐ AmeriVantage
☐ Av-Med
☐ Blue Cross/Blue Shield
☐ CarePlus Health
☐ Citrus Health
☐ Freedom Health
☐ HealthSun
☐ Humana
☐ Leon Medical Centers
☐ MD Medicare Choice
☐ Medica Healthcare
☐ Preferred Care Partners
☐ Prestige South Choice
☐ Quality Health Plans
☐ Secure Horizons AARP
☐ Summit Health
☐ Vista Healthplan
☐ WellCare
☐ Veterans
☐ Private Insurance
☐ Other: ____________
☐ Don't know

☐ Private Insurance (specify): ______________________________

Section 6

Contact Information: Please tell us who to contact if you become ill during class?

Last Name: ______________________ First Name: ______________________

Relationship: ☐Child ☐Grandchild ☐Parent ☐Sibling ☐Spouse

☐Other Relative (*specify*) ________________________

☐Other Not Relative (*specify*) _____________________

Address: ____

Unit/Apt #: ______ City: ____________________ State: ____ Zip Code: __________

Home Phone: Area Code _______ Number ___________________________

Work Phone: Area Code _______ Number ___________________________

Cell Phone: Area Code _______ Number ___________________________

THANK YOU!

ENHANCE FITNESS®

HEALTH FOUNDATION of south florida

Health History Form

Name ______________________ Home Phone__________

Address______________________________

Emergency Contact (Name)______________(Phone Number)________

Doctor's Name: ______________________

Doctor's Address: ______________________

Doctor's Phone Number: ______________________

Part I: Healthy History

A.1. Do you have history of any of the following conditions? (If yes, note the year it began next to the box.)

Y	N		Y	N		Y	N	
☐	☐	Heart disease	☐	☐	Foot/ankle swelling	☐	☐	Knee injuries
☐	☐	High blood pressure	☐	☐	Smoking (#/day___)	☐	☐	Back problems
☐	☐	Congestive heart failure	☐	☐	Lung disease	☐	☐	Broken bones
			☐	☐	Shortness of breath	☐	☐	Osteoporosis
☐	☐	Irregular/rapid heart beats	☐	☐	Stroke	☐	☐	Parkinson's
			☐	☐	Diabetes	☐	☐	Dizziness or blurred vision
☐	☐	Chest pain/angina	☐	☐	Surgery in past year			
☐	☐	Heart attack	☐	☐	Hernia	☐	☐	Weakness
☐	☐	Heart surgery	☐	☐	Seizures or epilepsy	☐	☐	Fall(s)
☐	☐	Pacemaker/defib	☐	☐	Blackouts	☐	☐	Unsteadiness
☐	☐	Cholesterol >240	☐	☐	Severe headaches	☐	☐	Cancer
☐	☐	Poor leg circulation left__ right__ both__	☐	☐	Double vision	☐	☐	Artificial joint (Where?________)
			☐	☐	Memory loss			
☐	☐	Arthritis				☐	☐	Alzheimer's

A.2. Additional Information: ______________________________

____

____

A.3. What medications do you take?______________________________

____

A.4. Do you have any allergies to food or medications? If yes, please list:

____

Part II: Self Assessment

B.1. Please circle your answer to each of the questions below:

a. Do you believe you are physically fit?	Yes	No
b. Are you happy with your current weight?	Yes	No
c. Can you stand up from a chair without using the arm?	Yes	No
d. Can you get up from the floor without assistance?	Yes	No
e. Can you stand on one leg without support?	Yes	No
f. Can you walk up and down steps without using the handrail?	Yes	No
g. Can you walk around a city block without being short of breath?	Yes	No

B.2. What exercise do you currently do on a regular basis?
(*Please circle and state number of times per week next to the exercise*)

Walk	Bike	Skate	Weight Lift
Jog	Dance	Tai-Chi	Martial Arts
Row	Swim	Tennis	Aerobics
Yoga	Stretch	Other	______________________

B.3. What do you wish to accomplish by attending and participating in this exercise program? ____

____

I, ______________________, hereby acknowledge that all the above information is true. I release ____ (provider agency), the Health Foundation of South Florida, and Senior Services (Seattle, WA) and all of its agents from all liability for any accident, injury or damages of any kind to persons or property that might occur while I participate in an EnhanceFitness® class.

____

Signature *Date/Time*