

**Confidential Demographic Information**

Put Requisition  
Sticker Here

**PLEASE PRINT CLEARLY ALL INFORMATION ON THIS PAGE**

**Date of Birth:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_      **Last 4 digits of Social Security. #:** \_\_\_\_\_

**Membership ID#** \_\_\_\_\_ (found on your Insurance card)

**Legal Name:** \_\_\_\_\_ **Gender:** M F  
First Name      Middle Initial      Last Name

**Circle the answer that fits your status:**    **Employee**      **Spouse**      **Dependent**

**Company:** \_\_\_\_\_ **Location:** \_\_\_\_\_

**Marital Status (circle one):** Single    Married    Separated    Divorced    Widowed    Partnered

**Mailing Address:** \_\_\_\_\_

**City, State:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**Home Phone #:** ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_      **Cell Phone #:** ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

**Work Phone #:** ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_      **Email :** \_\_\_\_\_

**Best Time to contact you (check):**    **Morning** \_\_\_\_    **Afternoon** \_\_\_\_    **Evening** \_\_\_\_

Please be advised... a representative of Living Well Health Solutions may contact *YOU* for Critical lab values or missing information.

**LivingWell Health Solutions is required, by law,** to protect your personal healthcare information. This means that your individual health information and personal demographic data will be kept **STRICTLY CONFIDENTIAL** and will NOT be shared with your employer or any other person or institution without your specific written permission.

**ONLY To be filled out by a LivingWell Health Solutions representative**

**Assessment Date:** \_\_\_\_\_

**Wt** \_\_\_\_\_ (lbs.)      **Ht.** \_\_\_\_\_ ft \_\_\_\_\_ in \_\_\_\_\_      **B/P** \_\_\_\_\_ / \_\_\_\_\_

**Body Fat %** \_\_\_\_\_      **BMI** \_\_\_\_\_      **Waist (inches)** \_\_\_\_\_      **Hip (inches)** \_\_\_\_\_

**TC** \_\_\_\_\_      **HDL** \_\_\_\_\_      **LDL** \_\_\_\_\_      **Tri** \_\_\_\_\_      **Glucose** \_\_\_\_\_      **PSA** \_\_\_\_\_

**This Participant is Pregnant** \_\_\_\_ ( ✓ if yes)      **Cotinine** \_\_\_\_\_

**This Participant has an Implanted Electrical Devise / Pacemaker** \_\_\_\_ ( ✓ if yes)

**This Participant has brought blood work from their Physician and is within 120 days** \_\_\_\_ ( ✓ if yes)

PLEASE PRINT ALL INFORMATION



Last First MI

Facility Name

# Health Risk Appraisal

Please provide an answer for each question by filling in the circle  
All of the information provided IS KEPT CONFIDENTIAL

## Personal Description

SEX: Male  Female  Physiology: Height ft \_\_\_ in \_\_\_ Weight \_\_\_ / \_\_\_ / \_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_ Origin: Asian  Hispanic  Caucasian  African American  Native American   
Women only: Are you pregnant: YES  NO

## Health Related Behaviors

### TOBACCO USE:

How would you describe your tobacco use habits?  
I have never used tobacco products   
I used to use tobacco products  I still use tobacco products   
Do you now use or have you used in the past any of the following: Cigarettes  Cigars  Smokeless Tobacco  Pipe

### ALCOHOL USE:

How many drinks of alcoholic beverages do you have in a typical week : [ Ex: One drink = 1 beer, glass of wine, shot of liquor, or mixed drink ]  
0  3 or less  4 to 6  7 or more

How often in the past have you had feelings of remorse after drinking :  
Never  Daily or Almost Daily  Weekly   
Monthly

Have you felt that you should cut down on your drinking :  
No  Yes, but not in the last year  Yes, during the last year

Has a family member and/or personal friend annoyed you by criticizing your drinking :  
No  Yes, but not in the last year  Yes, during the last year

### MEDICATION USE:

How often do you use medications or drugs which affect your mood or help you to relax :  
Rarely or never   
Sometimes   
Almost every day

### PHYSICAL EXERCISE:

In the average week, how many times do you engage in physical activity for at least 20 minutes [ Ex: exercise or work which makes you breathe heavily and makes your heart beat faster ]  
0  1 to 3  4 or more

## Physician Information

Personal Physician :  
Doctor's Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_

If a Clinical Staff Member needs to contact you, what would be the best time:  
Morning  Afternoon  Evening   
Home Phone Number \_\_\_\_\_  
Mobile Phone Number \_\_\_\_\_

STRICTLY CONFIDENTIAL

**Quality Of Life Indicators**

**SLEEP AND REST:**

How many hours of sleep do you usually get each night:

- 6 or less                       8   
 7                                   9 or more

**TENSIONS AND ANXIETIES:**

How often do you feel tense, anxious, out of control, or depressed:

- Often                                   Rarely   
 Sometimes                                   Never

**PERSONAL LOSS OR MISFORTUNE:**

Have you suffered a personal loss or misfortune in the past year:

[EX: Job loss, disability, divorce, separation, jail term, bankruptcy, or the death of someone close to you]

- No, none   
 Yes, one serious loss     Yes, two or more serious losses

**PERSONAL ILLNESS:**

In the past year, how many days of personal illness have you had that kept you out of work:

- 0 days                                   3 to 5 days   
 1 to 2 days                                   11 or more days

**Medical History And Self-Care**

**HEALTH SERVICE UTILIZATION:**

In the past year, how many times have you:

- Visited a Doctor's office or clinic  
Gone to an Emergency Room
- Stayed overnight in a Hospital  
Used a 1-800 number for medical advice
- Been treated with Alternative Medicine  
(Acupuncture, Herbs, Chiropractic, etc.)

<u>NONE</u>	<u>1-2</u>	<u>3 or More</u>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Medical History And Self-Care (Continued)**

**PROACTIVE HEALTH STEPS:**

Have YOU made any of these changes to enhance your health during the past 12 months:

	<u>YES</u>	<u>NO</u>
Increased physical activity Lost weight	<input type="radio"/>	<input type="radio"/>
Reduced alcohol use Quit or cut down on smoking	<input type="radio"/>	<input type="radio"/>
Reduced fast food intake Lowered Blood Pressure	<input type="radio"/>	<input type="radio"/>
Lowered Cholesterol Levels Cope better with stress	<input type="radio"/>	<input type="radio"/>
Sleeping more	<input type="radio"/>	<input type="radio"/>

PREVENTATIVE SERVICE OR SCREENING:

When was the last time YOU had these preventative services or Health Screenings performed:

	<u>LESS THAN A YEAR</u>	<u>1-4 YEARS AGO</u>	<u>5 OR MORE YEARS</u>	<u>NEVER</u>
Colon Cancer Screening Rectal Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flu Shot Tetanus Shot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood Pressure Cholesterol Check	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Eye Exam Stress EKG	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing Test Dental Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FOR WOMEN: PAP Test Mammogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FOR MEN: Prostate Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Thank you for your participation in the  
Employer Sponsored Wellness Program!**

**Please read and sign the Agreement to Participate in Employer Sponsored  
Wellness Program & to Release Personal Health Information**

# Agreement to Participate in Employer Sponsored Wellness Program & to Release Personal Health Information

By signing this document, I knowingly and willingly agree to participate in the Wellness Program sponsored by my Employer in conjunction with LivingWell Health Solutions and satisfactorily meet any wellness guidelines established by my Employer for the program.

In addition, I authorize LabCorp, my health plan's pharmacy benefit management company, my insurance company, and the nurse practitioner who will staff the on-site clinic as part, and as an independent contractor, of the LivingWell Health Solutions Program (and not an employee of my Employer), all of whom are subject to Health Insurance Portability and Accountability Act of 1996 (HIPAA), to disclose my personal medical information to LivingWell Health Solutions. In addition, I authorize my Employer to release my personal demographic information to LWHS to facilitate the distribution of program information to me at my home.

I understand that, unless prohibited by state and /or federal law, the protected health information is to be disclosed under this authorization so that LivingWell Health Solutions' employees and representatives may: 1) define my unique health risk; 2) evaluate my health service utilization patterns; 3) develop an individual health risk reduction plan for me; 4) provide care and evaluate outcomes of such activities; 5) track the evolution of my risk factors over time; and 6) determine the types of health education I may need to increase my awareness of my health risk issues and the service options available to me to address them. This information may also be used to compile aggregate summary statistical data reports; and, may be used by LWHS on a de-identifiable basis to support its internal business processes.

This authorization shall remain in force until such time as I notify LivingWell Health Solutions of my desire to withdraw from the program. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and include my full name, company name, and date of birth. It should be sent to the attention of the Clinical Services Director of the LivingWell Health Solutions program at the address listed below.

LivingWell Health Solutions  
8757 Red Oak Blvd • Suite 250  
Charlotte, NC 28217  
ATTN: Medical Director

Print Participant Name: \_\_\_\_\_ Date: \_\_\_\_\_

Participant's Signature: \_\_\_\_\_

THANK YOU FOR YOUR PARTICIPATION  
ALL INFORMATION THAT YOU HAVE PROVIDED  
WILL BE KEPT STRICTLY CONFIDENTIAL

