Wellness Welcome Packet

"Invest In Your Health"

Congratulations! You have taken an important step to improve the quality of your life. You have taken action!

Medical Network One's Michigan Institute for Health Enhancement welcomes you to our program and we look forward to helping you achieve and maintain a healthier lifestyle.

Our multidisciplinary team consists of the following disciplines: registered nurses, registered dietitians, certified diabetes educators, certified exercise specialists, behavior health specialists and wellness counselors all here to provide you with customized care to help you meet your health and wellness goals.

We have several features that ensure that our program best suits your needs. For example, educational sessions are delivered one-on-one to allow you to learn at your own pace and focus on the topics that are of most interest to you.

In addition to one-on-one educational sessions with members of our multidisciplinary team, you will also have:

- Assessments with each discipline, repeated every 3 months
- Individualized workout plans
- Customized meal plans
- Coaching calls made by our wellness counselors to keep you motivated between appointments
- Access to our professional care team on-line, via a secure e-mail system.

To ensure the full time allotted for your appointment, please **COMPLETE** the following forms and bring them to your first appointment. If you need further assistance, give us a call at **866-648-3265** or visit us on the web at www.mednetone.net.

Please Read Carefully.
Documents must be completed in advance and
brought to your first appointment.

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How did you hear about us? *Check one below*

☐ Physician ☐ Health Fair ☐ Promotion ☐ Friend/Relative ☐ Speaking Event ☐ Advertisement
☐ Worksite ☐ CCTT ☐ CHANGE ☐ Health Plan ☐ Other: ______________________

HEALTH AND NUTRITION HISTORY

Name: ____ Date: _________________

Patient Information:
If you have questions or concerns, do not hesitate to ask. The information you share will help the staff member have a better understanding of your needs.

Date of Birth: _______________ Height: ________Weight: __________

Initial BMI: _________________ Initial Blood Pressure: _____________

Phone: _____________________ Email: _________________________

Medical History:

CONDITION	YES	NO	COMMENTS
High Blood Pressure			
High Cholesterol/High Triglycerides			
Congestive Heart Failure			
Heart Disease			
Diabetes Type 1 or 2			
Hyper/Hypothyroid			
COPD			
Ulcerative Colitis			
Crohn's Disease			
GERD			
Kidney Disease			
Asthma			
Chronic Pain			
Other:			

List any current medications, supplements, or over-the-counter remedies: (please list dosage if known)
____
____
____
____

List any food allergies, intolerances, or food items you dislike:
____
____

Have you experienced a significant weight gain or loss in the past 6 months? ____________________
If yes, explain: ____

Medical Network One
Michigan Institute For Health Enhancement

Have you made any recent changes to your health, exercise, or eating habits? If yes, what changes have you made?

____
____

Do you notice you eat for reasons other hunger? If yes, please explain.

____

How much stress have you experienced lately?

____
____

How many hours of sleep do you get on average? ____

Who do you feel is your support system; people who will help you if you need it?

____

How would you describe your energy level? ____

Do you have an active or sedentary job? ________________________
If active how many hours per week do you perform laborious activity? ____________________________

Do you currently exercise? _______________

If yes please fill out the table below:

Activity	Time Spent (min)	Days per week

What activities or exercise have you participated in the past?

Activity/Exercise	Time Spent (min)	Days per Week	Benefits	Reason for Stopping

What, if any, physical limitations do you have? Please explain.

____
____
____

Looking forward, by the end of your participation in this program, what do you hope to have accomplished? ____
____

I certify that the above information is true to the best of my knowledge. If there are any changes to my health status, I understand that it is my obligation to inform the staff of Medical Network One's Michigan Institute for Health Enhancement.

Signature: ____ Date: __________________________

Print Name: ____

RELEASE OF INFORMATION TO PHYSICIAN

(To be completed by patient)

As part of your participation in Medical Network One's Michigan Institute for Health Enhancement programs, we send quarterly updates to your physician/clinician regarding your progress and attendance.

Please indicate below the name, phone number and address of the physician/clinician you would like your reports sent to.

Physician Name____

Address ____________________________ City______________ Zip Code__________

Phone Number (_____) ________________ Fax Number (_____) ________________

Email Address ________________________

_________ (please initial) I give permission to Medical Network One's Michigan Institute for Health Enhancement to contact the above named physician/clinician regarding my progress in the program(s).

ACKNOWLEDGEMENT OF VOLUNTARY PARTICIPATION FORM

Name: ____

Emergency Contact Person: _______________________________ Phone: _______________________

In consideration of the benefit to be derived from my participation in Medical Network One's Michigan Institute for Health Enhancement Wellness Program, I voluntarily, unconditionally, and irrevocably agree to release and hold harmless Medical Network One and the Michigan Institute for Health Enhancement, their employees, agents, and assigns, from liability for any claims, demands, actions, and causes of action arising from my participation in the Wellness Programs.

____   _________________________

Participant's Signature   Date

Print Name: ____

CANCELLATION POLICY ACKNOWLEDGMENT FORM

This serves as acknowledgement that Medical Network One's Michigan Institute for Health Enhancement requires a 24 hour minimum notice for appointment cancellations. Appointments cancelled with less than 24 hours notice are subject to a $35 cancellation fee. Please note that being more than 15 minutes late for your appointment may result in a need for your appointment to be rescheduled.

_______________________________________ _____________________

Signature Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have received the attached Notice of Privacy Practices.

____ _________________________

Participant or Personal Representative's Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's

relationship to the patient: ____

MEDIA RELEASE FORM

OPTIONAL

Consent to Photographs and Videotapes for Medical Network One's Michigan Institute for Health Enhancement Convention and Presentation materials.

I voluntarily, unconditionally, and irrevocably agree to release and hold harmless Medical Network One and the Michigan Institute for Health Enhancement, their employees, agents, and assigns, from liability for any claims, demands, actions, and causes of action arising from my permission for Medical Network One and the Michigan Institute for Health Enhancement to take, reproduce, and use photographs and or videotape, in connection with the production of programs for convention and presentation purposes.

I disclaim any rights to such photographs or materials.

I am 18 years of age or older and competent to sign this release, and do so voluntarily, having read and understood its contents.

____ ___________________________

Participant's Signature Date