MY BEST HEALTH PROGRAM OVERVIEW

My Best Health is a lifestyle program designed to support long-term, healthy behavior changes. Participants are provided with professional support and resources during the six-month program and work with the My Best Health Team to set attainable goals based on their personal health journey. The goal of this program is to prevent, arrest and reverse chronic disease, like obesity, while increasing healthy behaviors such as physical activity, healthy eating and overall personal well-being. We commend you on your decision to participate in the My Best Health program.

Duration: Program runs for six months. Program maintenance is available once you have completed the six months.

Cost:

- Regular Registration: $250 nonrefundable
- Discount available for Parkview co-workers

If you are experiencing financial hardship, but are interested in the program, please contact the Center for Healthy Living to inquire about financial assistance.

Participants who enroll in the program must complete all sessions outlined below by the end of 6 months. See cover sheet for specific dates.

Wellness coach – Completion of three 30- to 60-minute telephone or in-person sessions (one at beginning, midpoint and end of program) are required, but you may see the health coach up to six times if preferred. The role of the wellness coach is to:

- Provide overview of the program.
- Define participant's vision of ultimate healthy self.
- Establish monthly and weekly goals for fitness and nutrition.
- Identify potential barriers and determine strategies to overcome barriers.
- Set progressive, realistic and measurable weekly fitness and nutrition goals.

Registered nurse – Completion of two 30- to 60-minute in-person sessions (one at beginning and one at end of program) are required. The role of the registered nurse is to:

- Review information provided in the enrollment packet and discuss areas of concern.
- Answer any clinical questions regarding existing medical conditions and monitor progress.
- Educate on blood work biomarkers and refer to physician, if applicable.

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MY BEST HEALTH PROGRAM OVERVIEW CONTINUED

Registered dietitian – Completion of three 30- to 60-minute telephone or in-person sessions every other month is required. The registered dietitian will:

- Discuss medical, weight and dieting history, medications, lab values, allergies, supplements, diet log and social eating environment.
- Review serving sizes, food choices and methods to improve nutrition through food choices.
- Set a calculated calorie goal appropriate for weight loss and determine method of tracking.
- Examine food records and meal patterns to create a nutrition plan.

Personal training – Completion of monthly 30- to 60-minutes in-person sessions are required for five months. The personal trainer will:

- Perform body composition analysis of body fat measurements, circumference measurements and weight (bring exercise log).
- Individualize weekly exercise prescription.
- Personal training sessions tailored to the participant, including one of the three components of fitness: cardio, resistance and/or flexibility.

Support group sessions – Completion of three 45- to 60-minute in-person group sessions are required, but you are encouraged to attend all sessions. Participants must attend the first session to review program components.

Program resources include:

- Free limited fitness membership to Greater Fort Wayne, Cole Family Center, or Parkview Warsaw YMCAs.
- Newsletters, weekly tips, recipes and workouts.
- Motivating, educational lectures.

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MY BEST HEALTH ENROLLMENT APPLICATION

The goal of the My Best Health program is to provide professional support and resources to people in our community who are ready to make long-term, healthy lifestyle behavior changes to manage their weight and lower their risks for chronic disease.

Enrollment Process

To complete the enrollment process, please complete the following requirements:

1. **Read the enclosed My Best Health Program Description.**
2. **Cost: $250 or Parkview co-worker discount (non-refundable). See complete details on cover letter.**
   Payment will be due upon acceptance to the program. Credit card is preferred. If you are interested in the program but are experiencing financial hardship, but are interested in the program, please contact the Center for Healthy Living to inquire about financial assistance.
3. **Complete all attached forms A – F:**
   a. Informed Agreement/Consent
   b. Physician Release Questionnaire
   c. Pre-assessment
   d. Clinical Assessment
   e. Three-day Food Record
   f. One-week Exercise Log
4. **Provide a copy of your most recent fasting lipid panel and fasting glucose panel (within the last three months) or A1C from your doctor, or obtain a requisition from the Parkview Center for Healthy Living to access our lab for a Package A test for $35. This must be turned in within one week of acceptance to the program.**
5. **Deliver all completed forms listed in section #3 and lab results in section #4 to the Center for Healthy Living, using one of the following methods:**
   - Fax to 260-458-6005, attn: Taylor Yoder
   - Send via interoffice mail (if Parkview Health co-worker) to Parkview Noble Hospital, Community Health Improvement, c/o Taylor Yoder
   - Scan and email to taylor.yoder@parkview.com

Next steps

Your completed paperwork and latest blood work will help us determine your qualification into the program. If you qualify, a welcome letter with further instructions will be sent to the email address that you provide.

Contact Taylor Yoder at 260-347-8126 or taylor.yoder@parkview.com if you have any questions regarding the enrollment forms. We are excited to support you in your efforts to take charge of your health.

Taylor Yoder
Supervisor
Parkview Center for Healthy Living,
Community Learning Center, Kendallville

Melissa Buesching
Well-Being Coordinator
Parkview Center for Healthy Living,
Parkview Warsaw YMCA location

Shawn Richardville
Community Well-Being Supervisor
Parkview Center for Healthy Living,
Woodland Plaza location

MY BEST HEALTH INFORMED AGREEMENT/CONSENT

Participant Information

Full name: _____

Date of birth: _____

Mailing address: _____

_____

Best contact information: ☐ Phone: _____

☐ Email address: _____

Which location would you like to participate in (you may only choose one location):

☐ Noble ☐ Warsaw ☐ Allen

1.	I agree to fully engage* in at least 80 percent of the in-person, telephone or email weight management education sessions for six months to help me control my weight. *Engagement is not measured on weight loss alone. It includes completing the food and exercise logs, and creating wellness goals and an exercise plan that you and the My Best Health team have agreed upon. Engagement is adopting exercise and nutrition habits that were not originally in your lifestyle.	☐ YES	☐ NO
2.	I understand that it is my responsibility to schedule, cancel and/or reschedule my sessions with the My Best Health team including the health coach, registered nurse, registered dietitian and personal trainer.	☐ YES	☐ NO
3.	I understand that cancelling my appointments less than 24 hours in advance will result in a "no show."	☐ YES	☐ NO
4.	I understand that two "no shows" will result in termination from the program.	☐ YES	☐ NO
5.	I understand that I am participating in a program that depends on my willingness and readiness to change my lifestyle and health behaviors.	☐ YES	☐ NO
6.	I understand that before I start any exercise program, I will first talk with my physician.	☐ YES	☐ NO
7.	I understand that if I miss scheduling a monthly appointment, this will be considered a "no-show."	☐ YES	☐ NO
8.	I fully release from liability and waive all legal claims against Parkview Health and all of its subsidiaries for any and all claims that are in any way connected with my participation in the My Best Health program.	☐ YES	☐ NO
9.	I acknowledge that I have read this form in its entirety or it has been read to me, and I understand my responsibility in the My Best Health program in which I will be engaged. I accept all risks, rules and regulations set forth. Knowing I have had the opportunity to ask questions which have been answered to my satisfaction, I consent to participate in the My Best Health – Weight Management Education Program sessions.	☐ YES	☐ NO

Print name: _____ Signature: _____

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MY BEST HEALTH
PHYSICIAN'S RELEASE QUESTIONNAIRE

Name: _____

1.	Are you a male over age 40?	☐ YES	☐ NO
2.	Are you a female over age 50?	☐ YES	☐ NO
3.	Do you have high blood pressure or are you currently taking medication to control high blood pressure?	☐ YES	☐ NO
4.	Do you have high cholesterol or are you currently taking medication to control cholesterol?	☐ YES	☐ NO
5.	Do you currently smoke or have you quit smoking in the last six (6) months?	☐ YES	☐ NO
6.	Are you inactive? (Not currently involved in a regular exercise program)	☐ YES	☐ NO
7.	Do you have insulin-dependent diabetes?	☐ YES	☐ NO
8.	Do you know of any reason why you should not exercise?	☐ YES	☐ NO

If you have answered "YES" to three or more of these questions, for your safety, your location's fitness facility will require a physician's release form prior to exercising. Please provide this with your enrollment packet submission.

I acknowledge that I answered these questions honestly and to the best of my ability.

Signature: _____ Date: _____

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MY BEST HEALTH PRE-ASSESSMENT

Full name: _____

Mailing address: _____

Phone number: _____ Email: _____

How did you hear about the program? (Please check all that apply):

Flier ☐ Email ☐ Co-worker ☐ Other: _____

Weight knowledge and behavior

Have you checked your weight within the last 30 days? ☐ YES ☐ NO

If yes, what is your current weight? _____

Do you know what your BMI is and has it been checked within the last 30 days? ☐ YES ☐ NO

If yes, what is your BMI? _____

Have you had your waistline measured within the last 30 days? ☐ YES ☐ NO

If yes, what is your waistline measurement in inches? _____

Do you know what your percentage of body fat currently is? ☐ YES ☐ NO

If yes, what is your body fat percentage? _____

Have you had a cholesterol test done in the past six months? ☐ YES ☐ NO

If yes, what is your total cholesterol? _____

What are your LDL levels? _____

What are your HDL levels? _____

What are your triglyceride levels? _____

Please list ways in which you think you can raise HDL _____

Please list ways in which you think you can reduce LDL _____

Have you checked your blood pressure within the last 30 days? ☐ YES ☐ NO

If yes, what was your last systolic (top number) blood pressure reading? _____

If yes, what was your last diastolic (bottom number) blood pressure reading? _____

Stage of readiness to change

Which statement best describes how ready you are to continue to manage your weight and health behaviors?

☐ I won't or can't manage my weight and health behaviors.

☐ I might manage my weight and health behaviors.

☐ I will manage my weight and health behaviors.

☐ I am currently managing my weight and health behaviors.

☐ I am still, and have been for a while, managing my weight and health behaviors.

MY BEST HEALTH PRE-ASSESSMENT CONTINUED

Tracking

How often do you check your weight?

☐ Every day

☐ Every 2-4 days

☐ Once a week

☐ I don't weigh myself

Meal planning

Are you currently following a specific meal or calorie plan to control your weight? (For example, low-fat, low-sodium, 1700 meal plan, low carb, etc…)	☐ YES	☐ NO
Do you know how many calories you should consume daily for your body frame size and weight loss goals?	☐ YES	☐ NO
Are you participating in Weight Watchers?	☐ YES	☐ NO
If yes, how many points were you given? _____		
Can you identify appropriate portion sizes for protein, grain, etc…?	☐ YES	☐ NO
Do you periodically track or log your meals manually, or on any online resource?	☐ YES	☐ NO
Do you track how many fruits and vegetables you consume in a day?	☐ YES	☐ NO

Exercise

To me, physical activity/exercise is: (check all that apply)

☐ Something I know I should do, but do not enjoy.

☐ Something I do only when I am trying to lose weight.

☐ Part of my regular lifestyle.

☐ Something I am currently not doing, but am committed to begin with this program.

I feel confident in my knowledge of aerobic exercise and resistance exercise, including the benefits and importance of each.	☐ YES	☐ NO
I get at least 30 minutes of physical activity most days, above and beyond what I do at work.	☐ YES	☐ NO

MY BEST HEALTH CLINICAL ASSESSMENT

Weight history

What is your height, in inches? _____ What is your current weight, in pounds? _____

Progression of weight gain pattern (age 18 to current)

☐ No pattern

☐ Steady, gradual increase of weight over the years

☐ Sudden increase of weight with pregnancies

☐ Variable weight gain/loss due to intermittent diet and exercise (regained weight when stopped program)

☐ Maintained consistently over the years

Weight loss attempts

List the most recent supervised diet attempts first, then list other diets within past seven years.

Name/type of diet attempt:	Dates of diet (month/year)	Beginning weight	Pounds lost	Pounds gained	Supervised by a physician, dietitian or weight management program?
	From: To:	_____ Lbs.	_____ Lbs.	_____ Lbs.	☐ YES ☐ NO
	From: To:	_____ Lbs.	_____ Lbs.	_____ Lbs.	☐ YES ☐ NO
	From: To:	_____ Lbs.	_____ Lbs.	_____ Lbs.	☐ YES ☐ NO

Medical history

Have you ever had any of the following:

Check all that apply. Some may require physician's release form.

☐ High blood pressure
☐ Knee pain
☐ Diabetes
☐ Ankle/foot pain
☐ Sleep apnea
☐ Swelling of feet
☐ Daytime sleepiness
☐ Urinary stress incontinence
☐ Snoring
☐ Blood clots
☐ Reflux (heartburn)
☐ Stroke
☐ Heart disease
☐ Shortness of breath
☐ COPD
☐ Asthma
☐ Heart failure
☐ Emphysema
☐ Chronic bronchitis
☐ Headaches
☐ High triglycerides
☐ Migraines
☐ Joint pain
☐ Kidney disease
☐ Back pain
☐ Seizures
☐ Hip pain
☐ Arthritis
☐ Eating disorder
☐ Cancer
☐ Depression
☐ Irregular periods
☐ Substance abuse

Medications

Please list all of your medications including any vitamin, mineral, herbal or other dietary supplements. Include the amounts for each medication.

_____

_____

Exercise history

I am physically unable to exercise due to: _____

If you are able to exercise, do you currently have a regular routine? ☐ YES ☐ NO

If yes, what does your aerobic exercise routine include? _____

How many times per week do you complete aerobic exercises? _____ times per week

Do you do resistance exercises (weights, bands, etc…)? ☐ YES ☐ NO

If yes, how many times per week do you complete resistance exercises? _____ times per week

Dietary history

Which of the following habits is part of your daily eating pattern? (check all that apply)

☐ Overeating
☐ Excessive snacking
☐ Binging
☐ Fast food/dining out
☐ Disordered eating/eating disorder
☐ Home cooked meals
☐ Excessive portions
☐ Restaurant takeout
☐ Lack of knowledge on how to prepare healthy foods

Are your family meals served at regular times on most days? ☐ YES ☐ NO

Does your family eat together? ☐ YES ☐ NO

Do you consume sweetened beverages such as coffee, tea, soda, juice, etc…? ☐ YES ☐ NO

Do you consume alcoholic beverages? ☐ YES ☐ NO

If yes, how many drinks do you consume weekly? _____

Do you have any food allergies? ☐ YES ☐ NO

If yes, which foods cause a reaction? _____

What is the reaction? _____

MY BEST HEALTH FOOD LOG

Date	Breakfast	Lunch	Dinner	Snack/Extras

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MY BEST HEALTH EXERCISE LOG

Day 1
Day 2
Day 3
Day 4
Day 5
Day 6
Day 7

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