# REGISTRATION - Health/Physical Activity Assessment INFORMATION

(*one form per person)  Send completed registration form along with your check or money order to:* **Health Freedom Inc.  P.O. Box 67220 Baltimore, MD 21215**

Date____________________ COF Site ____________________T-Shirt size____________

First Name: _________________________Last Name: ____________________________

Address: __________________________________________________________________

City: ________________________________ State: ___________ Zip: ________________

Email: ____________________ Phone (AM): _______________ (PM) ________________

**Registration fees:  check all that apply**

☐ **6-Week Pre-Walk Training and Walk Events** - $15.00
☐ 6-Week Pre-Walk Family rate- $45 (two adults and up to 3 children)

**Walk Events (only) pre-registration (no training**)
☐ One Walk event  -  $15.00
☐ Family rate- $45 (two adults and up to 3 children)

☐**On- site/Late Registration fee**: $20.00
☐  Ages 0-10 years:  FREE
☐  Ages 11-18 years: $10.00

**Please select the walks you are planning to attend:**
**☐Anne Arundel County ☐Baltimore City☐Baltimore/Howard Counties**
**☐St. Mary's Counties ☐Dorchester County  ☐Kent County ☐Montgomery County**
**☐Prince Georges County ☐Somerset Counties**

$ Total______________
(non-refundable)

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Waiver of Responsibility: In consideration of my participation in the Health Freedom: A Path to Wellness, I assume full responsibility for all risks associated with running/walking in any of the events including, but not limited to:  falls, contact with participants, the effect of weather, traffic, conditions of the course, etc. All such risks are known and appreciated by me.  Having read this wavier and knowing these facts and in consideration of the acceptance of my entry, I, for myself and anyone entitled to act on my behalf, my heirs and assigns and my estate, hereby waive and forever discharge all the sponsors, organizers, their representatives and successors from all claims or liabilities of any kind arising out of my participation in any of the Health Freedom events or resulting from carelessness on the part of the persons named in this document.  I attest that I know that running/walking is a potentially hazardous activity and I should not participate in Health Freedom events unless I am medically able.  Further, I grant permission to all organizers involved to use any photographs, motion pictures, or any other record of this event for any legitimate purpose. Parent or guardian signature required if under 18 years of age.

Signature_____________________________________________Date________________

Office Use Only Fee Paid _____                    Date Rec'd_______

***(In case of emergency, list name and phone number of individual to notify):***

**Name**_________________________ **Phone No.**__________ **Relationship**____________

Name________________________________

# Physical Activity Assessment Form

NOTE: Moderate activities are defined as brisk walking or other usual daily activity equal to brisk walking.

You may need to check with your doctor before beginning or changing your physical activity habits. To find out, circle **YES** or **NO** for each question as it applies to you. If you answered ***YES*** to any of the questions, talk to your doctor by phone or in person. Tell him/her the question that you answered **YES**.

a. Has your doctor ever recommended only medically supervised activity? **YES** **NO**

b. Do you often have pain or pressure in your mid-chest, left side neck, shoulder or arm during or right after physical activity? **YES** **NO**

c. Have you developed chest pain over the last month? **YES** **NO**

d. Do you tend to lose consciousness or fall down due to dizziness? **YES** **NO**

e. Do you feel extremely breathless after mild exertion? **YES** **NO**

f. Has your doctor told you to take medicine for your blood pressure or a heart condition? **YES** **NO**

g. Has your doctor said you have bone or joint problems that could be made worst by the proposed activity? **YES** **NO**

Please check the top three (3) reasons you decided to participate in the Circle of Friends Walking Group:

- ❑ I want to exercise and/or walk with others.
- ❑ It will motivate me to start exercising or walking regularly.
- ❑ It will motivate me to increase my current level of physical activity.
- ❑ My conductor (walk leader) encouraged me to participate.
- ❑ Family, co-workers or friends encouraged me to participate.
- ❑ I want to honor the struggle of my ancestors.
- ❑ I want to improve my physical health.
- ❑ I want to lose weight.
- ❑ I want to improve my mental health and/or feel better about myself.
- ❑ I want to improve my appearance

**FOR OFFICE USE ONLY**

☐ Referral Made
☐ Physician consent received
☐ No Referral Necessary
Comments:

| DEMOGRAPHIC INFORMATION | | I.D. | DATE |
|---|---|---|---|
| BALTIMORE | | MARYLAND | *ZIP CODE: 212*______-____ |
| D.O.B. | AGE | GENDER ☐ Male ☐ Female | |

**RACE: Which of the following best represents your race? (Check all that apply.)**

☐ African American/Black ☐ Caucasian/White ☐ American Indian or Alaska Native

☐ Native Hawaiian or other Pacific Islander ☐ Other:______________________

**ETHNICITY: Are you Spanish/Hispanic/Latino?** ☐ Yes ☐ No

**LANGUAGE: What is your primary language?** ☐English ☐ Spanish ☐Other

**MARITAL STATUS:** ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

☐ Never Married ☐ Partnered or In a Relationship

**CURRENT HOUSING STATUS:** ☐ Permanently Housed (house, apartment)

☐ Temporarily Housed (friends, family) ☐ Homeless or Living in Shelter

**EDUCATION: What is the highest grade in school you completed?** ☐ Less than High School

☐High School graduate or GED ☐Some college or Technical School ☐College Graduate

**EMPLOYMENT: Are you currently employed?** ☐ Yes ☐ No

**INCOME: What is your current annual household income (gross)?** ☐ Less than $15,000

☐ $15,000-$24,999 ☐ $25,000-$49,000 ☐ $50,000-$74,999 ☐ $75,000 or More

**HEALTHCARE ACCESS: Do you currently have some type of private or public healthcare coverage, health insurance (examples include: prepaid insurance plans which may or may not be paid by your employer) or government plans (i.e. Medicaid or Medicare, etc.)?**

☐ Yes ☐ No ☐ Don't Know/Not sure

**If Yes, what type of healthcare coverage do you use to pay for most of your medical care?**

☐ Medicare A or B ☐Both Medicare A and B ☐Medicaid (i.e., Healthchoice, etc.)

☐Champus, Champus-VA, Tricare, or Military ☐Purchased directly (by you or someone else)

☐ Employer or union-based (you or someone else) ☐ Other ☐ Don't Know/Not sure.

**MEDICAL HISTORY: Has a doctor, nurse, or other health professional EVER told you that you had any of the following? (Check all that apply to you.)**

| | | |
|---|---|---|
| ☐ Chronic Pulmonary Disease | ☐ Arthritis | ☐ Asthma |
| ☐ High or Abnormal Cholesterol | ☐ High Blood Pressure | ☐ Heart Attack |
| ☐ Chest Pain or Coronary Heart Disease | ☐ Anxiety | ☐ Cancer |
| ☐ Childhood or Adolescent Obesity | ☐ Congestive Heart Failure | ☐ Depression |
| ☐ Diabetes during pregnancy | ☐ Pre-Diabetes | ☐ Type 1 Diabetes |
| ☐ Type 2 Diabetes | ☐ Other Mental Condition | ☐ Drug Abuse |
| ☐ Osteoporosis or Hip/Foot Fracture | ☐ Stroke | ☐ Kidney or Renal Disease |
| ☐ Other Medical Condition | ☐ Don't Know/Not Sure | ☐ Other: _______ |

**ADDITIONAL RISK FACTORS: Has anyone in your family had a history of:**

☐Heart Disease or Stroke ☐Diabetes ☐Hypertension or High Blood Pressure

**THE BALTIMORE CARDIOVASCULAR HEALTH DISPARITIES INITIATIVE**
***Faith-based Education***

I.D.: ________________________________ Date: ______________________

**HEALTH STATUS (complete as many as possible)** **DATE RECORDED**

| | | |
|---|---|---|
| 1. Height: | ______'______" | ____/____/_______ |
| 2. Weight: | ____________lbs | ____/____/_______ |
| 3. Waist circumference | ____________ | ____/____/_______ |
| 4. Blood Pressure: | ____________ | ____/____/_______ |
| 5.BMI | ____________ | ____/____/_______ |

## Health Behaviors:

6. Do you have at least 5 servings of fruits and vegetables per day at least 5 days per week?
☐ YES ☐ NO

7. Do you have 30 minutes or more of moderate, or 20 minutes or more of vigorous, physical activity per day, at least 5 times per week? ☐ YES ☐ NO

8. Do you currently smoke cigarettes, a pipe, or cigars? ☐ YES ☐ NO
If YES, how often do you smoke a tobacco product? ☐EVERYDAY ☐SOME DAYS

9. In general, would you say your health is:
☐ EXCELLENT ☐ VERY GOOD ☐ GOOD ☐ FAIR ☐ POOR

10. Did a doctor recommend you take aspirin daily or every other day? ☐ YES ☐ NO

**MEDICAL CARE: IN THE PAST 6 MONTHS…**

11. …have you been to the emergency room? ☐ YES ☐ NO
If YES, how many times? __________

12. ...have you been admitted to the hospital? ☐ YES ☐ NO
If YES, how many times? __________

13. ...have you taken all your medicines as prescribed? ☐ YES ☐ NO
If NO, for what reason? (Check all that apply)
☐ DON'T KNOW HOW TO USE ☐ CAN'T READ THE INSTRUCTIONS
☐ CANNOT AFFORD COPAYMENT ☐ DON'T THINK IT IS NECESSARY
☐ DON'T LIKE THE SIDE EFFECTS ☐ OTHER REASON: ____________

14. ...have you been scheduled for a routine doctor's appointment? ☐ YES ☐ NO

15. ...did you miss any doctor's appointments? ☐ YES ☐ NO
If YES, how many: __________