FIRST STEP PROGRAM APPLICATION

Name: _____
(Last) (First) (Initial)

Address: _____

City/Town: _____ Postal Code: _____

Home Phone #: _____Work Phone #: _____

Date of Birth (mm/dd/yy): _____ Age: _____

Occupation: _____

Provincial Health Number: _____

Emergency Contact: _____ (_____) Phone #: _____
Relation to you

Physician: _____ Physician's Phone #: _____

The information you provide will be considered as privileged and confidential
Please allow up to 1 week to be contacted by program staff to set up your initial assessment

THE FIRST STEP PROGRAM

Partnership between:

City of Saskatoon

Saskatoon Health Region

LiveWell™ Optimizing Chronic Disease Management

Please Return To:
First Step Program
2020 College Drive
Saskatoon, SK.
S7N 2W4
OR
Fax to 975-3377
If you have any questions
please call: 975-3121

FOR OFFICE USE ONLY
CODE: FWC 01 FWH 01
SUPPORT:
START DATE:
GRAD DATE:
PAYMENT: RECEIVED POST DATED CHEQUES: YES NO

CARD #: CASHIER:

Health History Questionnaire

Name: _____

This information you provide will be used to assist you in designing your program to meet your distinctive needs.

1. Have you ever been **diagnosed with**, or had any of the following: **Please explain.**

- ☐ Heart condition (heart attack, coronary bypass or other heart surgery, angina)

  Have you ever been investigated for a heart problem?

  - ☐ yes: Please explain:
  - ☐ no:
- ☐ Diabetes:
- ☐ Pre-Diabetes (Impaired Fasting Glucose or Impaired Glucose Tolerance):
- ☐ Peripheral Vascular Disease (Claudication):
- ☐ Chronic lung disease
  - ☐ asthma:
  - ☐ emphysema:
  - ☐ chronic bronchitis:
  - ☐ other: _____
- ☐ Chronic Kidney Disease
- ☐ Stroke/t.i.a.(transient ischemic attack):
- ☐ High blood pressure:
- ☐ Abnormal cholesterol levels:
- ☐ Hypothyroidism:
- ☐ Hyperthyroidism:
- ☐ Heart murmurs:
- ☐ Sleep apnea:
- ☐ Epilepsy or seizures:
- ☐ Anemia (“low blood”):
- ☐ Arthritis:
- ☐ Bursitis/Tendonitis:
- ☐ Osteoporosis:
- ☐ Increased body weight:
- ☐ Neurological problems:
  - ☐ Multiple Sclerosis:
  - ☐ Parkinson’s Disease:
  - ☐ Other: _____
- ☐ Mental Health issues:

2. Do you ever experience any of the following? **Please explain.**

- ☐ Chest discomfort:
- ☐ Extra, skipped, or rapid heart beats, or palpitations:
- ☐ Ankle swelling:
- ☐ Unusual shortness of breath:
- ☐ Light-headedness or fainting:
- ☐ Cramping, burning or discomfort in lower legs:
- ☐ A chronic, recurrent cough:
- ☐ Migraine or recurrent headaches:
- ☐ Swollen, stiff or painful joints:
- ☐ Foot problems:
- ☐ Limited range of motion in joints:
- ☐ Knee problems:
- ☐ Back problems:
- ☐ Shoulder problems:
- ☐ Neck problems:
- ☐ Recurrent or chronic pain of any sort:

  Please specify: _____

3. Do you have any **other medical problems** not mentioned previously? **Please explain.**

4. Do you have any **allergies**?

5. Please list any **medications** you are currently taking, including **dosage and times/day**.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Are you unsure of any medication names? YES / NO

6. Please list any severe illness, hospitalization, surgical procedure, or broken bones within the past two years:

7. Have you seen your **doctor** in the past year? YES / NO
Is your doctor aware that you wish to participate in this exercise program? YES / NO

8. Have you ever **smoked**? YES / NO

If YES: How many packs a day? _____
How many years? _____
Are you currently smoking? YES / NO
If YES: Are you considering quitting in the near future? YES/NO
If NO: When did you quit? _____

9. Do you have a **blood relative that had heart problems** when he/she was less than 55 years? old? YES / NO If yes, please explain:

10. Please list your current, **regular physical activities**:

Type of activity _____

Frequency (times/week) _____

Length of time _____

11. Is this the first time you have participated in an exercise program? **Please explain.**

12. How did you hear about the First Step Program?

- ☐ Friend
- ☐ Dr's Referral
- ☐ Other Health Professional
- ☐ Media
- ☐ Leisure Guide
- ☐ Building Resistance to Heart Disease and Diabetes
- ☐ Discovering Diabetes
- ☐ Other

13. What **program times** will you most likely be attending?

- ☐ Tuesday, Thursday and Saturday mornings
- ☐ Tuesday and Thursday Evening and Saturday Morning
- ☐ A mix of both morning and evenings

I have answered all questions truthfully and to the best of my knowledge. I have not knowingly withheld any information regarding my health.

Signature: _____ Date: _____

If cost is a barrier for you please bring your most recent Notice of Assessment from Revenue Canada to your assessment, if you do not have a copy it can be obtained by calling 1-800-959-8281. Request the Option C Form or a Verified Copy of your most recent Income Tax Return.

Thank you for your interest in attending the First Step Exercise program, your application will be reviewed and a program coordinator will contact you shortly to set up an appointment for an assessment.

[i]If you have any questions please contact 975-3121 or 655-6929.

[i] Revised January 2010 SH