Diabetes Exercise Program

Application Packet

ALL packet contents must be filled out completely. Only completed packets will be considered for the Exercise Program, incomplete packets will be returned for completion.

Packet consists of:

- Application
- Contract Agreement
- My Starting Point
- PAR-Q

Return packet to:

Siletz Community Health Clinic
Diabetes Program Assistant
PO Box 320
Siletz, OR 97380

If you have any questions feel free to call:
Toll-free: 800.648.0449 X1661
Direct: 541.444.9661
Fax: 541.444.9678



Amended 10/17/12

Diabetes Exercise Program
APPLICATION

STAFF USE	
Date Rec'd: Area: RF:	Priority: Approved:

Full Legal Name:_____ Date of Birth:_____
Please print

Complete **mailing** address:_____

Home phone:_____ Cell Phone:_____

Are you an enrolled Siletz tribal member? ❑ YES ❑ NO Roll #:_____

Are you an enrolled member of a federally recognized tribe other than Siletz? ❑ YES ❑ NO

Tribal Affiliation:_____

Have you been diagnosed with diabetes? ❑ YES ❑ NO

If you **are not** diabetic, please answer the following:

1. Nearest relative that is diagnosed with diabetes (e.g. brother, mother, grandmother, etc):

   _____

2. Your current Weight:_____ Height:_____

3. If you are a woman, were you ever diagnosed as having gestational diabetes (diabetes during pregnancy) OR have you given birth to a baby over 9 pounds?
   ❑ YES ❑ NO

4. Have you ever been told that you have: ❑ "borderline diabetes", ❑ "metabolic syndrome" or ❑ "Pre-diabetes"? (please check the appropriate box)

5. Are you currently physically active? ❑ YES ❑ NO
   What kind of exercise or physical activity do you do?_____

   About how many minutes a week do you walk or exercise?_____

What facility do you receive your primary care?_____

Primary Care Provider Name:_____

_____ _____
Applicant Signature Date

Diabetes Exercise Program
CONTRACT AGREEMENT

Name:_____ Date:_____
Please print

Telephone Number:_____

I _____, agree to exercise a **minimum of 8 times each month** at the below listed facility of my choice:

Facility Name:_____

Facility Address:_____

_____

Facility Phone:_____

I agree to complete a "My Starting Point" annually, as requested by the Exercise Program, so my progress may be documented.

I agree to exercise safely and within my personal limitations. I deem the Siletz Community Health Clinic **not liable** for any injury or other accident that may occur over the course of my exercise program.

I understand that if I fail to attend at least 8 times a month that my membership may be discontinued; and in order to be considered for future funding, I must reapply to the Diabetes Exercise Program.

Should I choose at any time to end my exercise program, I agree to notify the Diabetes Program Assistant at the Siletz Community Health Clinic (541-444-9661) before fees for the next membership period are due. It is also my responsibility to notify my facility that I am terminating my membership in accordance to their membership policies.

I fully understand that the Siletz Tribal Diabetes Program reserves the right to discontinue funding for my exercise program at any time.

My signature indicates that I have read the Diabetes Exercise Program Contract thoroughly and agree to comply with these rules and regulations.

Signature:_____ Date:_____

Diabetes Exercise Program
My Starting Point

NAME:_____

There are many benefits of regular physical activity. Each of these measurements is directly related to the risk factors for heart disease and/or type 2 diabetes. You will find encouragement in the improvements you will be making.

This form must be filled out completely.
Weight should be within the past month, cholesterol test results and blood glucose within the past year. If you have been diagnosed with diabetes, include your latest A1C. Please contact your healthcare provider to assist you in filling in information. In the Salem, Eugene, and Portland Area Offices, Community Health staff can assist you with the *asterisked measures below.

TODAY'S DATE:_____

Age: _____ Height:_____ **Staff Use**: BMI

***Weight**:_____ ***Blood Pressure**:_____ ***Resting Pulse**:_____

***Waist Circumference**:_____

Last Cholesterol Test DATE:_____

TOTAL CHOLESTEROL:_____

HDL CHOLESTEROL:_____

LDL CHOLESTEROL:_____

TRIGLYCERIDES:_____

IF YOU **ARE** A DIAGNOSED DIABETIC:

LAST Hemoglobin A1C DATE:_____

A1C RESULT:_____

IF YOU **ARE NOT** A DIAGNOSED DIABETIC:

*BLOOD GLUCOSE:_____ ❑ lab value
❑ finger stick

Diabetes Exercise Program
Physical Activity Readiness Questionnaire (The PAR-Q)

Regular physical activity is fun, healthy, and safe for most people. However, some people should check with their doctor before becoming more physically active. If you are between the ages of 18 and 69, the PAR-Q will tell you if you need to check with your doctor before starting an exercise program. If you are over 69 years of age and not used to being very active, please check with your doctor.

Please read each question **carefully**, and answer each one **honestly** (Circle YES or NO):

1. Has your doctor ever said that you have a heart condition AND that you should ONLY do physical activity recommended by a doctor? **YES NO**
2. Do you feel pain in your chest when you do physical activity? **YES NO**
3. In the past month, have you had chest pains when you were NOT doing physical activity? **YES NO**
4. Do you ever lose your balance because of dizziness or ever pass out? **YES NO**
5. Do you have a bone or joint problem that could be made worse by a change in your physical activity? **YES NO**
6. Is your doctor currently prescribing drugs for you for a blood pressure or heart condition? **YES NO**
7. Do you know of any other reason why you should NOT do physical activity? **YES NO**

IF you answered YES to one or more questions:
Talk with your doctor before increasing your physical activity.
You may be able to do any activity you want as long as you start slowly and build gradually, or your doctor may want to restrict certain kinds of activities that may not be safe for you. Please sign below.

IF you answered NO to all questions:
You can be reasonably sure that you can safely begin an exercise program.
Remember to start slowly and build gradually to avoid injuries that can set your program back. Please sign below.

WAIVER

When starting an exercise program, I understand the importance of starting slowly, staying at a comfortable pace and increasing intensity gradually. I will stop exercising immediately, and seek medical attention, if I experience chest pains, palpitations, dizziness/fainting or any other unexplained problems while exercising. I hereby release the Siletz Community Health Clinic and CTSI employees from liability for any injuries or illness I may incur while participating in this program.

Signature:_____ Date:_____