Brooks Rehabilitation
Physician Form

Please complete the health questionnaire and physician form along with your medical provider.

Please contact your Wellness Team at brooks.wellness@brooksrehab.org for your assessment due date

1. Visit your health care provider in enough time to complete the health screenings listed on this physician form:
    a. You MUST have your health care provider complete all required areas of the form but keep the original copy of the form for your records. We can accept biometrics up to 90 days prior.

2. Complete the Paper Health Questionnaire:
    a. Please complete all 15 questions on the form and first name, last name, date of birth and Identifier. Please use your Member ID as the Identifier.

3. Send us the completed physician form and health questionnaire:
    a. *Please contact your Wellness Team at brooks.wellness@brooksrehab.org for your assessment due date.* It is your responsibility to ensure the physician form and health questionnaire are received by Health Designs – not the responsibility of the health care provider.

    - **By Secure Fax: 904-285-2779**
      OR
    - **By Secure Email: coaching@healthdesigns.net**
      OR
    - **By Mail: Health Designs**
      35 Executive Way Suite 110
      Ponte Vedra Beach, FL 32082

Thank you for taking the time to complete this screening. It will help you see how your lifestyle affects your health, and often acts as a motivator for behavior change.

Health Designs will process your information when we received your qualification form. To learn if we have received your paperwork and/or confirm the data we have recorded for you, you may contact Health Designs after the first business day of the next month at 904–285-2014 or email us at coaching@healthdesigns.net.

Please call our office at 904-285-2019 or e-mail coaching@healthdesigns.net to set up your coaching call.

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***Please note – we are only able to discuss this personal health information directly with the participant, in accordance with HIPAA and other privacy regulations.**

PARTICIPANT: Complete this section. Your signature verifies the information is complete and accurate.	
Name (Print Clearly)	
Signature	Date of Birth:
Phone Number with Area Code	For confirmation of receipt of paperwork via email, please provide your email address:
Mailing/Street Address (PRINT CLEARLY)	State/Zip Code
City	Member ID

Health Care Provider: Complete and sign this form for your patient to be considered a participant in Brook's wellness program.

EXAM DATE: ______________________

Health screening measures	Patient/Participant status	Notes
Height (determined **without** wearing shoes)	________ ft. ______ in.	
Weight (determined **without** wearing shoes)	________ lbs.	
Blood Pressure	_________ /_________mm/Hg	
Total Cholesterol	________ mg/dL	
HDL	____mg/dL	
LDL	____mg/dL	
Triglycerides	____mg/dL	
Glucose		
Fasting prior to blood work?	□ YES □ NO	

HEALTH CARE PROVIDER SIGN-OFF: I verify the information supplied is complete and accurate.		
Provider Name (Print Clearly)		Credential(s)
Provider Signature	Telephone	Email, if available
Office street address	City	State/Zip Code

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Health Designs

www.HealthDesigns.net (904)-285-2019

HEALTH QUESTIONNAIRE

This Health Questionnaire will ask you about your health lifestyle habits and is not intended to diagnose illness. The information obtained will be stored in a secure manner, consistent with HIPAA requirements.

Correct ***Incorrect*** ***Use blue or black pen, bubble in completely, print neatly in the text boxes.***

1. Are you an employee of this company or a spouse?
- Employee
- Spouse

2. Gender:
- Male
- Female

3. Do you currently have or been diagnosed with (bubble in all that apply):
- High blood pressure
- High cholesterol
- Diabetes

4. Do you currently take medication for (bubble in all that apply):
- Blood pressure
- Cholesterol
- Diabetes

5. Rate your current state of health?
- Great
- Good
- Average
- Below Average
- Poor

6. Do you use any tobacco products?
Examples: Cigarettes, pipes, cigars or smokeless.
- Yes
- No

7. How often is too much stress a problem for you?
- Never or rarely
- Sometimes
- Often
- Always

8. How many days a week do you get at least 30 minutes of continuous physical activity?
- 4 or more
- 3
- 1 - 2
- Never

9. In an average week, how many alcoholic drinks do you consume?
- None
- 1 - 2
- 3 - 7
- 8 - 14
- 15 or more

10. During a typical day, how many servings of high-fiber foods do you eat?
Examples: 1 slice whole grain bread, ¾ cup whole grain cereal, fresh fruit/vegetables, beans.
- 0 - 1
- 2 - 4
- 5 or more

11. During a typical day, how much of what you eat is high-fat versus low-fat foods?
Examples: High-fat foods include processed foods, fatty meats, creamy foods/sauces, whole milk, and fried foods.
- Mostly high-fat
- About half high-fat & half low-fat
- Mostly low-fat

12. During a typical day, how many sugared beverages do you drink?
Examples: 8-12 oz of soda, sweet tea, sports drink, fruit drinks, or sweetened coffee.
- None
- 1
- 2 - 3
- 4 or more

13. In the next six months, are you planning to make any changes to any of the following areas (bubble in all that apply):
- Nutrition
- Blood Pressure
- Stress
- Diabetes Mgt
- Exercise
- Cholesterol
- Tobacco
- Weight

14. Have you been fasting for the past 2 hours?
Nothing to eat or drink except water and unsweetened/black coffee/tea.
- Yes
- No

15. Is this your first time taking this assessment?
- Yes
- No

LAB INFORMATION

SBP | DBP | TC | HDL | LDL

Triglycerides | RATIO . | Glucose | A1C . | Cotinine

Height: feet, inches | Weight | BMI . | Waist Circumference .

First Name (Please Print Legal Name)

Date of Birth / /

Last Name (Please Print Legal Name)

Identifier (Internal Use Only)

53302

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