



# Program Application and Health History

## Contact Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Email: \_\_\_\_\_

### Phone Numbers:

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Home: \_\_\_\_\_

Do you grant us permission to leave you a message?

Yes:  No:

### Mailing Address:

Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: \_\_\_\_\_

Do you need an Accu-Chek Monitor sent to you?

Yes:  No:

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_

Is Medicare your Primary Insurance?

Yes:  No:

Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

## Take Control

P.O. Box 9132

Missoula, MT 59807

Email: [takecontrolmt@gmail.com](mailto:takecontrolmt@gmail.com)

Phone: 1.800.746.2970

Fax: 1.800.746.2970

Website: [www.takecontrolmt.com](http://www.takecontrolmt.com)

Please email, fax or mail your completed application to the above address.

*Eat Well. Stay Active. Reduce Your Risks.™*

## Diabetes History

### What type of diabetes do you have?

Type I \_\_\_\_\_  
Type II \_\_\_\_\_  
Year of Diagnosis \_\_\_\_\_

### Most recent A1C result:

Result: \_\_\_\_\_

Date taken: \_\_\_\_\_

### Do you have a family history of?

Diabetes: Yes: \_\_\_ No: \_\_\_

Heart Disease: Yes: \_\_\_ No: \_\_\_

## General Health Questions

Height \_\_\_\_\_ Weight \_\_\_\_\_ Usual Body Weight (Last 3 months) \_\_\_\_\_

Do you smoke? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Do you chew tobacco? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Do you drink alcoholic beverages? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If yes, how many per week: \_\_\_\_\_

### Do you have?

1. High Blood Pressure Yes: \_\_\_ No: \_\_\_
2. High Cholesterol Yes: \_\_\_ No: \_\_\_
3. Coronary Artery Disease Yes: \_\_\_ No: \_\_\_
4. Other \_\_\_\_\_

### Have you?

Been hospitalized or visited the ER in the past 6 months?

Yes: \_\_\_ No: \_\_\_

Reason: \_\_\_\_\_

## Self-Care History

Have you had a dilated eye exam in the last year? Yes: \_\_\_ No: \_\_\_ Date of exam: \_\_\_\_\_

Have you been to the dentist in the last 6 months? Yes: \_\_\_ No: \_\_\_ Date of exam: \_\_\_\_\_

Have you received a flu vaccination within the last year? Yes: \_\_\_ No: \_\_\_

Have you ever received a pneumococcal (pneumonia) vaccination? Yes: \_\_\_ No: \_\_\_ Date: \_\_\_\_\_

Do you wear a medical ID? Yes: \_\_\_ No: \_\_\_

Do you feel confident in managing your diabetes? Yes: \_\_\_ No: \_\_\_

Have you been diagnosed with neuropathy? Yes: \_\_\_ No: \_\_\_

## Additional Information

## Diabetes History

What type of diabetes do you have?

Type I \_\_\_\_\_

Type II \_\_\_\_\_

Gestational \_\_\_\_\_

Year of diagnosis: \_\_\_\_\_

Do you have a family history of?

Diabetes: Yes: \_\_\_\_ No: \_\_\_\_

Heart Disease: Yes: \_\_\_\_ No: \_\_\_\_

## Self-Care History

Have you had a dilated eye exam in the last year? Yes: \_\_\_\_ No: \_\_\_\_ Date of exam: \_\_\_\_\_

Have you been to the dentist in the last 6 months? Yes: \_\_\_\_ No: \_\_\_\_ Date of exam: \_\_\_\_\_

Have you received a flu vaccination within the last year? Yes: \_\_\_\_ No: \_\_\_\_

Have you ever received a pneumococcal (pneumonia) vaccination? Yes: \_\_\_\_ No: \_\_\_\_ Date: \_\_\_\_\_

### Foot Care:

How often do you exam your feet? \_\_\_\_\_

How would you describe your ability to examine your feet: \_\_\_\_\_

When was your last professional foot exam ? \_\_\_\_\_

Have you been diagnosed with neuropathy? Yes: \_\_\_\_ No: \_\_\_\_

## Personal Health and Wellness Goals

What are your goals/educational needs while participating in the Take Control Program?

1.

2.

3.

Have you received diabetes education in the past? If so, where and when?

\_\_\_\_\_

## Additional Information

## Liability Release

This is a legally-binding **Liability Release, Waiver, Discharge, and Covenant Not to Sue** made by me, \_\_\_\_\_ (print your name) to Take Control, Inc.

I fully recognize that I am voluntarily participating in the Take Control program and there may be instances in which Take Control offers suggestions/advice regarding an exercise plan. I understand that as a participant in the Take Control program, it is advised and encouraged that I consult with my physician prior to beginning any exercise program and/or use of fitness facilities and/or exercise equipment.

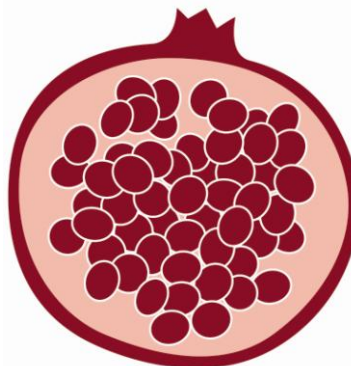
I understand that Take Control does not **require** me to participate in any given physical activity, but I want to do so. Therefore, I agree to assume and take upon myself all of the risks and responsibilities in any way associated with these recommended activities. I release Take Control from any and all liability, claims and actions.

I assure Take Control that I will fully disclose/communicate any health-related reasons or problems which preclude or restrict my participation any recommended activities. I understand that this Release means I am giving up, among other things, rights to sue the Take Control. I also understand that this Release binds my heirs, executors, and administrators, as well as myself.

**I HAVE READ THIS ENTIRE RELEASE, I FULLY UNDERSTAND IT, AND I AGREE TO BE LEGALLY BOUND BY IT.**

\_\_\_\_\_  
Take Control Participant Signature

\_\_\_\_\_  
Date



**Eat Well. Stay Active. Reduce Your Risks.™**