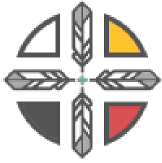

FourPoints HEALTH

# FourPoints Health

**SPECIAL DIABETES PROGRAM FOR INDIANS**

## Applicant Information

Full Name:_______________________________________________ *Date:*_______________
*Last* *First* *M.I.*

Address:______________________________________________________________
*Street Address* *Apartment/Unit #*

______________________________________________________________
*City* *State* *ZIP Code*

Phone:____________________________ Email:________________________________

Starting Date:__________________ Birthdate:__________________ Age:_______________

How did you hear about this program?_____________________________________________

Are you diabetic? Yes ☐ NO ☐

Do you get at least 150 minutes of physical activity a week? Yes ☐ NO ☐

Are you trying to lose/gain weight? Yes ☐ NO ☐ If yes, list weight loss/gain___________

Are you: Paiute Tribal Member, Spouse, Legal Guardian, Other (Circle One)

Short term goal:______________________________________________________________

What are some of your health goals:_____________________________________________

## Health Assessment

Height:__________ Weight:__________

## Disclaimer and Signature

☐ I certify that my answers are true and complete to the best of my knowledge.

☐ I understand that I must commit fully to the FourPoints Health 1 – year program, which requires at least 150 minutes a week of physical activity, monthly check-ins and a monthly survey. Failure to do so will result in termination or suspension from the program.

☐ I authorize to the consent of releasing my health information to/from the FourPoints Health clinics.

Signature:_____________________________________________ Date:__________________