Welcome to the Wellness Challenge!

The Wellness Challenge is about feeling your best. It's about getting rid of what drags you down and replacing it with what brings energy to your life: a plant-based diet, regular exercise, healthy social connections, and mindfulness. We'll help you to create a healthy body and lifestyle through lectures, discussions, interactive exercises, cooking demos, food samples, and more.

Medically Approved and Amazingly Effective

During this 6-week program our trained facilitators will help you to:

- Lose weight safely, effectively, and permanently while you significantly reduce high cholesterol, blood sugar, and blood pressure and your need for prescription drugs
- Reduce your risk of chronic disease, including heart disease, cancer, and diabetes
- Learn which foods add to your health and which subtract from it
- Develop a simple but invigorating exercise program that will add life to your years
- Embrace the Wellness Challenge philosophy: Progress, not perfection

Fall 2017 Southampton Wellness Challenge Schedule

There are seven weekly sessions over the course of six weeks. All sessions are 1 ½ hours except for session one, which is two hours long.

There's a lot of information to talk about, so try not to miss any sessions.

Sag Harbor

Tuesdays: Start at 6:00 pm
September 19, 26, Oct. 3, 10, 17, 24, 31

Wellness Foundation
34 Bay Street, Suite 205
Sag Harbor, NY

The $150 materials fee includes *The Wellness Challenge Guidebook*, *Wellness Challenge Jumpstart Guide*, food for demonstrations and tastings, and other supplies. The Wellness Challenge fee is non-refundable.

Registration forms and payment must be received by noon on the business day BEFORE your Wellness Challenge starts. The ONLY exception is the lab test report, which MUST be submitted before your second session. You may not attend session 2 if your labs are outstanding. It may take some time to get your doctor's consent and the blood work results, so get on it right away.

Questions? Call or email us. We're always happy to help.

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info@wfeh.org 631-329-2590

Fax your completed registration packet to 329-3714.

REGISTRATION IS EASY
JUST FOLLOW THESE STEPS!

1 Fill out these forms and fax to 329-3714 or info@wfeh.org ASAP:

☐ Participant's consent
☐ Liability release
☐ Wellness Challenge Questionnaire

2 Contact your doctor for:

☐ Signed physician's consent
☐ TWO prescriptions for blood work: lipid panel and A1c
(one for before you start the Challenge and one for the 6th week of the Challenge)
Blood work done 30 days prior to start date will be accepted
Fasting is required

3 Get your blood work done

Ask your doctor to send the blood work directly to us at **329-3714 or** info@wfeh.org

Some doctors may require you to make an appointment before signing physician's consent or providing blood work prescriptions.

If your insurance company will not pay for the blood work, we have arranged a reduced rate of $30 per visit with Southampton Hospital (726-8250). When making the appointment just let them know that you are participating in the Wellness Challenge.

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Wellness Challenge Participant's Consent

Name (print) ____ Date ___________________

First choice location _____________________ Second choice location____________________

Name for name tag ___________________________________ Date of Birth ______________

Mailing address ____

City ____ Zip ______________

E-Mail address ____

Preferred telephone Home / Cell / Work _________________

Have you participated in the Wellness Challenge before? Yes   No

Cholesterol, triglycerides, and glucose measurements tell if you are at risk for cardiovascular disease and diabetes and following the results over time can mark your progress. Even though our bodies need some cholesterol, triglycerides, and glucose for good health, too much of any one of these can give way to disease.

When you go to the lab to have your blood drawn, ask them to fax the results to us at 329-3714. Ensuring that lab results reach the Wellness Foundation office is YOUR responsibility not the responsibility of your doctor.

Participant's Informed Consent:

I, ____ (name of participant) have read and understand all the information and requirements describing the Wellness Challenge. I have been given the opportunity to discuss it and to ask questions. All my questions have been answered to my satisfaction. I voluntarily consent to participate in this program.

____   __________________

Participant's Signature   Date

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Intention, Disclosure, and Liability Release

INTENTION:

It is the intention of Wellness Foundation (the Foundation) and its directors, officers, employees, and volunteers to provide information in regard to nutritional excellence, stress management, fitness, attitude, and the power of thoughts and words. The role of the Foundation will be as a facilitator. It is expected that people receiving information from the Foundation and/or participating in any of its meetings will be responsible for their own health and will be under the care of a medical professional for that purpose.

DISCLOSURE:

Douglas D. Mercer, Chairman and Founder of the Foundation has no professional training, degrees or certificates in regard to wellness. All of his knowledge on the subject has been gained through personal experience by attending wellness institutes, studying professional literature, speaking and consulting with medical professionals, learning through experiences of family, friends, and acquaintances, and learning through changing his own habits.

LIABILITY RELEASE:

The undersigned fully understands that he or she is responsible for any changes in lifestyle habits that he or she may choose to make. The undersigned also agrees to indemnify and hold Douglas D. Mercer, the Foundation, and/or its directors, officer, employees, or volunteers harmless from all claims, judgments, expenses and costs, including but not limited to attorney's fees incurred in connection with any claims brought as a result of his or her involvement in the Foundation and/or participation in any of its meetings or any of the Foundation's programs including the Wellness Challenge and subsequent support including, but not limited to, any claim of medical complications, allergic reaction, or failure to achieve his or her desired health benefit.

Wellness Foundation programs and classes are designed to teach skills to achieve and maintain a healthy weight and to improve health. The program is not intended to be instructional for medical diagnosis or treatment. Please consult with your physician before beginning any of the Foundation's programs or any other weight loss program. If there is a change in your medical condition as a result of your participation in any of the Foundation's programs, you should immediately notify your physician.

____
Legal name (print)

____ ____________________
Participant's Signature Date

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Wellness Challenge Physician's Consent

DOCTOR FORM

The Wellness Challenge is a guided nutrition program in which the participants are encouraged to reduce fat consumption, to eliminate processed foods, dairy, and meat, and to increase whole natural plant foods, including whole grains, fresh fruits and vegetables, legumes, and nuts and seeds. Moderate physical exercise is also encouraged. The Wellness Challenge teaches the skills to achieve and maintain a healthy weight, to reduce the risk of disease, and to become more physically fit. The program is not intended to be instructional for medical diagnosis or treatment.

To help quantify your patient's progress, please provide him or her with **beginning and completion prescriptions for lipid panel and hemoglobin A1c blood tests.** Completion blood tests are to be done 6 weeks from the start of the program. Giving both prescriptions at once is preferred.

On the prescription, please indicate that a copy be sent directly to the patient.

Please indicate any limitations your patient may have to participating in the Wellness Challenge here.

By signing this form, I give my consent as the physician of (Participant's name)____to participate in the Wellness Challenge. I also agree to discuss any medical issues associated with the requested laboratory results with the participant and to provide any necessary medical advice regarding the results of such laboratory tests.

Physician's Name (print) ____

Physician's Signature ____

Address ____

Date ____

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Wellness Challenge Questionnaire

Your answers to these questions help your facilitator to focus on the topics that are most important to you. The information will be kept strictly anonymous unless we obtain your approval to do otherwise.

Please complete the questionnaire except for the sections highlighted in gray.

Name (print)____ Age ___________

Date of birth______________________________ Male or Female (please circle)

Profession ________________________________

How did you hear about the Challenge?

Have you previously tried another program to improve your health? If so, explain.

If you have already made changes to your diet that coincide with the recommendations of the Wellness Challenge, please give an approximate date that you made those changes. _____/_____/_________

List your main health concerns. Include all currently diagnosed conditions.

Do you smoke and, if so, how much?

List all drugs that you take, including prescription drugs, over-the-counter medications, and natural/herbal remedies. Indicate the dosage you take.

Beginning _________________________________ _____________________________________

_________________________________ _____________________________________

Ending _________________________________ _____________________________________

_________________________________ _____________________________________

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Incentive, Goals, and Reward

Set one principal wellness goal to be accomplished in the course of the six week program. Please choose from the following and indicate the specifics of your goal. For example, if weight loss is your goal, check weight loss and indicate how many pounds you would like to lose on the line that follows.

______ Weight loss: ____

______ Reduce cholesterol: ____

______ Reduce glucose: ____

______ Reduce physical ailments: ____

______ Reduce food cravings: ____

______ Reduce stress: ____

______ Increase energy: ____

______ Other: ____

Body and Laboratory Measurements

Weight and waist-circumference measurements will be taken during Session One and during Session Six. Blood test results are those derived from the blood test reports you provide us. We will record those numbers in the questionnaire.

	Beginning	Ending
Weight	____________	_____________
Waist measurement	____________	_____________
Total Cholesterol	____________	_____________
LDL Cholesterol	____________	_____________
HDL Cholesterol	____________	_____________
Triglycerides	____________	_____________
Hemoglobin A1c	____________	_____________

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Physical Conditions
Fill in the number, on a scale of 0 to 10 (0 never and 10 always) that represents your experience.

	Beginning	Ending
Allergies	________	________
Congestion - head and upper respiratory	________	________
Headaches	________	________
Sore or stiff muscles or joints	________	________
Back pain	________	________
Heartburn, acid reflux	________	________
Gastrointestinal discomfort	________	________
Skin problems	________	________
Fatigue	________	________
Crave sugar	________	________
Crave fat	________	________
Crave salt	________	________
Eat to reduce emotional pain	________	________
Eat to reduce day-to-day stress	________	________
Lethargic and lack of vigor	________	________
Lack of concentration and focus of mind	________	________
Difficulty sleeping	________	________
Depression, unpleasant mood	________	________

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Quality of life

Which best describes how you perceive your health-related quality of life?

Beginning		Ending	
________	Excellent	________	Excellent
________	Very Good	________	Very Good
________	Good	________	Good
________	Fair	________	Fair
________	Poor	________	Poor

Food & **Beverage Choices**

Over an **average day** how many servings of the following foods do you eat?

	Beginning	Ending	Intention for next 6 months
Meat, including fish and poultry, eggs	________	________	________
Dairy (milk, butter, cheese, yogurt, ice cream, etc.)	________	________	________
Whole grains (wheat, barley, rice, oats, quinoa, etc.)	________	________	________
Grain products other than "whole"	________	________	________
Vegetables, fresh and frozen	________	________	________
Fruits, fresh and frozen	________	________	________
Nuts and seeds	________	________	________
Beans and lentils	________	________	________
Added oils in salad dressings, recipes, and for cooking	________	________	________
Sweet deserts (not included elsewhere)	________	________	________
Healthful snacks (not included elsewhere)	________	________	________
Unhealthful snacks (not included elsewhere)	________	________	________

Over an **average day** how many of the following do you consume?

	Beginning	Ending	Intention for next 6 months
Glasses of water	________	________	________
Cups of caffeinated coffee or tea	________	________	________
Alcoholic drinks (1 drink= 5 oz. wine, 12 oz. beer, 1½ oz. liquor)	________	________	________

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Exercise

Note **the number of minutes per week** that you spend engaged in each activity.

	Beginning	Ending	Intention for next 6 months
Aerobic: Walk, bike, elliptical, jog, etc.	________	________	________
Stretching, mind-body: Yoga, Pilates, etc.	________	________	________
Strength training	________	________	________
Other: ___________________________	________	________	________

Stress

On a scale of 0-10 with 10 showing the most stress, how would you rate the stress level in your life? (Stress can include, but is not limited to family, home, finances, work, and health.)

Beginning	0	1	2	3	4	5	6	7	8	9	10
On completion	0	1	2	3	4	5	6	7	8	9	10

Accomplishments

To what extent did you accomplish your principal wellness goal? Please refer back to your primary goals on page 2 and indicate the extent to which you accomplished that goal. For example, if your goal was weight loss, check weight loss and indicate how close you came to achieving the goal on the line that follows.

_____ Weight loss: ____

_____ Reduce cholesterol: ____

_____ Reduce glucose: ____

_____ Reduce physical ailments: ____

_____ Reduce food cravings: ____

_____ Reduce stress: ____

_____ Increase energy: ____

_____ Other: ____

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Looking forward
Taking into account your family history, personal health, and risk factors for degenerative disease, what would be the negative effect on your health five years from now if you do NOT continue to exercise and eat a nutrient-rich diet as you learned to do during the Wellness Challenge? For example, do you think you would develop diabetes, heart disease, cancer, etc.?

Future Goals
What wellness goals would you like to achieve in the next six months? As at the beginning of the program, be realistic and be as specific as possible.

Support
What types of support would you find helpful for continuing this lifestyle? For example, would a more interactive website, support group meetings, or lectures and guest speakers provide motivation and guidance to stay focused?

A**bout the Wellness Challenge**
Score each item on a scale of 0 to 10 (0 no value, 10 very valuable).

Food demonstrations	___________	Facilitator presentations	___________
Recommended books	___________	Group support	___________
Overall benefit to you	___________	*Wellness Challenge Guidebook*	___________
Jumpstart Guide	___________	Accountability partners	___________

Your Guidance
Please share anything else you think would help us to improve the effectiveness of the program.

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Wellness Foundation Release Form

By signing this release form, I authorize Wellness Foundation to use the following personal information:

1) My picture including photographic, motion picture, and digital video images
2) My voice, including sound and video recordings

I hereby grant Wellness Foundation and its subsidiaries, licensees, successors and assigns, the right to use, publish and reproduce, for all purposes, my name, pictures of me in film or digital video form, sound and video recordings of my voice and printed and electronic copy of the information described in sections (1) and (2) above in any and all media including, without limitation, cable and broadcast television and the Internet, and for exhibition, distribution, promotion, advertising, sale, press conferences, meetings, hearings, educational conferences, and in brochures and other print media. This permission extends to all languages, media, formats and markets now know or hereafter devised. This permission shall continue forever unless I revoke the permission in writing.

I further grant Wellness Foundation all right, title, and interest that I may have in all finished pictures, reproductions and copies of the original print, and further grant Wellness Foundation the right to give, sell, transfer, and exhibit the print in copies or facsimiles thereof, for marketing, communications, or advertising purposes, as it deems fit.

I hereby waive the right to receive any payment for signing this release and waive the right to receive any payment for Wellness Foundation's use of any of the material described above for any of the purposes authorized by this release. I also waive any right to inspect or approve finished photographs, audio, video, multimedia, or advertising recordings and copy or printed matter or computer generated scanned image or other electronic media that may be used in conjunction thereof or to approve the eventual use that it might be applied.

I acknowledge that I have read the foregoing and I fully understand the contents.

IN WITNESS WHEREOF, I have executed this release on this _____ day of ____, 20 ____.

___________________________________ ___________________________________

Print Name Signature

____

Address

_______________________________ _____________________________________

Telephone number Email address

If the above signatory is under the age of 18 years, the parent or legal guardian of such person should sign below:

___________________________________ ___________________________________

Print Name Signature

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