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 discussions, interactive exercises, cooking demos, food samples, and more.

Medically Approved and Amazingly Effective

During this 7-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.

Wellness Challenge Fee

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

Winter 2018 Wellness Challenge Schedule

There are 7-weekly sessions over the course of six weeks. Session one is two hours long. The other six sessions are 1½ hours. There's a lot of information to talk about. Please attend all sessions!

Thursday:	January 18, 25, February 1, 8, 15, March 1, 8
Facilitator:	Casey McGowin
Tuesday:	January 23, 30, February 6, 13, 27, March 6, 13
Facilitator:	Peggy Kraus

All sessions start at 6:00 pm and are held at Wellness Foundation Offices
34 Bay Street, Suite 205, Sag Harbor, NY 11963

All completed registration documents, beginning labs, and payment are due **ONE WEEK** before classes start. You may not attend the first class if your labs, paperwork, and/or payment are outstanding.

You'll need to have blood work done (lipid panel and A1c) before beginning the program and again directly following the **WEEK SIX CLASS**. If you've had these tests within the last month, they can be used as the beginning tests. Blood work done before 30 days of the start date of your class will not be accepted. Please get **TWO** prescriptions for blood work from your doctor.

If your insurance company will not pay for the blood work, we have arranged a reduced rate of $30 per visit with Stony Brook Southampton Hospital Lab (631) 726-8250. When you arrive for your blood test, just let them know that you will be participating in the Wellness Challenge. They will bill you accordingly.

You will complete the remainder of the questionnaire in session six. Have your completion blood work done directly following **WEEK SIX** session. Your completion blood work is due in our office **TWO BUSINESS DAYS** before session 7/graduation. Completion blood work is important for your long-term success, and it helps to continue the program for others.

info@wfeh.org 631-329-2590

Fax your completed registration packet to 631-329-3714.

REGISTRATION IS EASY
JUST FOLLOW THESE STEPS!

1 Fill out these forms and fax to 631-329-3714 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 the beginning lab work and one for the completion lab work). Please have results FAXED to us: 631-329-3714.

3 Get your blood work done

Ask your doctor to fax the blood work directly to us at **631-329-3714 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 Stony Brook Southampton Hospital (631-726-8250). When making the appointment just let them know that you are participating in the Wellness Challenge.

Fasting is required.

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Wellness Challenge Participant's Consent

Name (print)_____ Date _____

Which session are you registering for? _____

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 blood drawn, ask them to fax the results to us at 631-329-3714. 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

info@wfeh.org 631-329-2590

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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 **TWO PRESCRIPTIONS** for blood work (beginning **and** completion prescriptions) for **lipid panel and hemoglobin A1c**. Completion blood tests are to be done 6 weeks after the start of the program. Please provide both prescriptions at once. On the prescription, please indicate that a copy be faxed directly to Wellness Foundation.

Please also **FAX** this consent form to us 631-329-3714 or give directly to your patient, thank you!

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 _____

info@wfeh.org 631-329-2590

Fax your completed registration packet to 631-329-3714.

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 _____ Your height _____

How did you hear about the Challenge?

Did your doctor refer you? Yes No Your doctor's name? _____

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

If you have already made changes to yourdiet 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 7-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?

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.?

After taking the Wellness Challenge do you now believe you have more control over your health than before? Please explain.

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?

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

Food demonstrations _____
Overall benefit to you _____
Jumpstart Guide _____
Facilitator presentations _____
Group support _____
Wellness Challenge Guidebook _____
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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