

Please print clearly, answer all questions, sign and return in the enclosed business-reply envelope.

NAME _____ PHONE NO. (home) _____
Last First Area Code

ADDRESS _____ PHONE NO. (work) _____
Street or P.O. Box Area Code

CITY _____ GENDER: F M
State Zip

DATE OF BIRTH _____ E-MAIL AVAILABILITY: Yes No
Month Day Year

HEALTH INSURANCE ID CARD NO. _____
(This will be your ID number for this program)

E-MAIL ADDRESS* _____
**This is optional, but by giving us your e-mail address, you allow us to send you additional information about The Healthy Weigh! Education Program.*

PHYSICIAN NAME _____ ADDRESS _____
Last First Street or P.O. Box

CITY _____
State Zip

Please answer these simple questions by filling in the correct answer. Your answers will be used to improve the health information we may send you in the future.

- What is your current weight? _____ lbs. What is your current height? _____ feet _____ inches
(Example: 5 feet 6 inches)
- How much weight would you like to lose? 10 lbs. 11-20 lbs. 21-40 lbs. More than 40 lbs.
- Why would you like to lose weight (check all that apply)?
 To improve my health To be more active/increase energy To have a more positive outlook about myself
- Do you have a family history of (check all that apply)?
 Heart Disease High Cholesterol Arthritis Cancer
 High Blood Pressure Diabetes Asthma Stroke
- Do you have a personal history of (check all that apply)?
 Heart Disease High Cholesterol Arthritis Cancer
 High Blood Pressure Diabetes Asthma Stroke
- How many days of work did you miss last year due to any/all of the illnesses you have checked above?
 0 days 1-3 days 4-5 days More than 5 days Not working
- How many days a week do you exercise for at least 30 minutes without stopping
 (example: walking, cycling, swimming — include taking stairs, etc.)?
 0 days 1 day a week 3 days a week 5 days a week Every day

(Continued on other side)

8. Have you tried to lose weight in the past year? Yes No
9. On a scale of 1-10, with 1 being least successful and 10 being most successful, please circle the number that rates the success of your weight-loss efforts this past year. 1 2 3 4 5 6 7 8 9 10
10. On a scale of 1-10, with 1 being least successful and 10 being most successful, please circle the number that rates your readiness to begin a program for weight loss. 1 2 3 4 5 6 7 8 9 10
11. Do you smoke or use other forms of tobacco? Yes No
12. Is there an overweight child in your family under the age of 18? Yes No

If yes, • What is your child's age? _____

• What is the child's weight? _____ lbs. Height? _____ feet _____ inches
(Example: 3 feet 5 inches)

13. Would you like to enroll your child in The Healthy Weigh? Yes No

If yes, please provide the child's name and address (if different from yours).

Child's name _____ Gender: F M

Address _____ City _____ State _____ Zip _____

We are very interested in providing you with information regarding managing your weight. Please list below any topics that you would like to see included in The Healthy Weigh! Education Program materials.

The Healthy Weigh! Education Program is for health education purposes only. We do not offer medical advice or medical services. Members always should consult their treating physician(s) for any medical advice or services. The member is responsible for selecting providers, services or products. **All referenced health services may not be covered under a health plan. Please check the terms of your health plan or insurance policy for coverage of services.** Information furnished by a member is kept strictly confidential and only used to provide information necessary for participation in or analysis of The Healthy Weigh! Education Program.

By my signature, I hereby indicate my decision to enroll in The Healthy Weigh! Education Program. I understand that there is no cost to me or my family for this program. I further authorize Arkansas Blue Cross and Blue Shield, Health Advantage and Blue Advantage to release my name and address for the purpose of my participation in mailings from The Healthy Weigh! Education Program. My information will not be furnished to third parties to include in shared mailing lists with other companies or organizations.

Signature (required): _____ Date: _____

Welcome to the program!



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association
arkansasbluecross.com



Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association
healthadvantage-hmo.com



**Blue Advantage
Administrators of Arkansas**
An Independent Licensee of the Blue Cross and Blue Shield Association
blueadvantagearkansas.com