# State Employee Wellness Center
## Employee Membership Packet

**Hours of Operation: Monday – Friday, 5:30 am – 6:30 pm**
**Saturday, 8:00 am – 12:00 pm**

Welcome to the State Employee Wellness Center operated by Healthbreak, Inc. We are looking forward to having you as a member. This facility provides an exciting and convenient opportunity for you to maintain or improve your overall health. The facility is staffed a dedicated number of hours per week by certified fitness professionals from HEALTHBREAK who will assist you in reaching your goals.
This packet contains the forms and information you need to become a member.

**Membership Packages:**
Monthly membership dues to the Wellness Center are only $27. All members are required to pay the monthly fee plus a one-time fee for a membership package. The two membership packages designed to get you started are described below.

**Personal Advantage Package**
**$75.00**

- Membership processing
- Orientation to the facility and equipment
- General exercise guidelines for cardiovascular, strength, and flexibility
- Choose between: **3 Personal training sessions** with a certified trainer/coach OR **1 Fitness Evaluation and 2 Personal training sessions** with a certified trainer/coach. Fitness Evaluation includes body composition, cardiovascular, muscular strength, muscular endurance and flexibility components. *($108 value. Must use within first 6 months of membership)*
- **Personalized fitness plan** to help you reach your health and fitness goals *($50 value)*

**Basic Start Package**
**$30.00**

- Membership Processing
- Orientation to the facility and equipment
- General exercise guidelines for cardiovascular, strength, and flexibility

**BEST VALUE**

**Membership Payment Options:**
Memberships are sold on a six-month basis with two options for payment:

1. Automatic monthly payment through a checking or savings account withdrawal. *(You pay only one month up front and subsequent months will be withdrawn through electronic funds transfer.)*
2. A minimum of six months membership paid in full by cash or check. *(If you purchase 12 months, you will receive one month FREE.)*

**Membership Enrollment Procedures:**

1. Read and understand the Wellness Center Rules and Regulations.
2. Complete the Health History Questionnaire. Your answers will determine if a medical release is required. If so, a medical clearance form will be provided to you.
3. Submit your forms in person to the Wellness Center, complete a membership contract, sign the facility waivers, and schedule your *Basic Start* appointment.
4. Attend your *Basic Start* orientation and YOU ARE A MEMBER!

***Congratulations on taking the first step to a healthier you! We are looking forward to helping you achieve a healthy lifestyle. If you have any questions, please call the Wellness Center at 303-866-2213 or email at statewellness@healthbreakinc.com.***
***Website: www.colorado.gov/dpa/wellnesscenter/index.htm***

# State Employee Wellness Center
## Rules and Regulations

1. Membership eligibility is limited to State of Colorado Employees only. Contractors, temps, or family members that are not employed by the State of Colorado are not allowed to use the facility.
2. If a Wellness Center member is no longer employed by the State of Colorado, whether voluntarily or involuntarily, that member will be released from the six-month membership contract and refunded any unused portion.
3. Prior to using the facility, all individuals must complete all required membership forms (health history, health facility release(s), and medical release if necessary, membership contract) and attend the *Basic Start* orientation with a staff member.
4. When entering and exiting the 1570 Grant Building to use the Wellness Center, all members must use the Wellness Center Entrance located at the rear of the building on the northeast corner.
5. Appropriate workout attire must be worn at all times. This includes shorts or sweat pants, shirts, and shoes. All jewelry and sharp objects must be removed prior to exercising.
6. There are lockers available in the locker rooms for daily use only. All members are encouraged to bring a padlock and lock all personal belongings. There are small permanent storage lockers available in the hallway for $3 per month. These lockers are rented on a six-month basis.
7. Toiletries including hairdryers, soap/shampoo and curling irons are available in the locker rooms. All members need to bring their own towels. Due to limited space in the locker rooms during peak times, please shower quickly and keep all personal belongings confined to a small space. Additional restrooms are located across the hall from the locker rooms.
8. The drinking fountain is located in the hallway between the locker rooms. Only water in non-breakable containers is allowed in the Wellness Center and locker rooms. No food or beverages are permitted.
9. Please limit your use of cardiovascular machines to 30 minutes if others are waiting.
10. When you are finished with a piece of equipment, please wipe off any perspiration using the disinfectant spray and paper towels located in both the cardio room and weight room.
11. Do not bang the weights. Heavy weightlifting with free weights must use a spotter. All free weight dumbbells and plates must be returned to their proper racks after use.
12. There are emergency phones located in both exercise rooms and each locker room. Please read and understand the Emergency Protocol posted next to each phone.
13. If you choose to exercise outdoors, please take your Wellness Center access card for re-entry to the building.
14. Please report any incidents, injuries and/or malfunctioning equipment to the fitness staff immediately. Do not attempt to fix the equipment yourself.

# State Employee Wellness Center
## HEALTH HISTORY QUESTIONNAIRE

### I. PERSONAL INFORMATION

**Date**: _____

**Name:** _____ **Gender (circle): Male or Female**
**First** **Last**

**Date of Birth:** ____/____/____ **Age:** _____ **Height:** _____ **Weight:** _____

**Building Location:** _____ **Department:** _____

**Job Title:** _____ **Email:** _____

**Home Phone:** _____ **Work Phone:** _____

**Person to Notify in Emergency:** _____ **Relationship:** _____ **Phone:** _____

### II. CURRENT EXERCISE PROGRAM AND GOALS

**How physically fit do you feel at present?**

❑ **Unfit** ❑ **Below Average** ❑ **Average** ❑ **Above average** ❑ **Very fit**

**Please complete the following according to your current exercise routine.**

| Activity | Sessions per Week | Minutes per Session |
|---|---|---|
| ❑ Cardiovascular Activity (walking, hiking, biking, etc.) | _____ | _____ |
| ❑ Resistance Training | _____ | _____ |
| ❑ Flexibility Training | _____ | _____ |
| ❑ Other (i.e Recreational Leagues) | _____ | _____ |

**What are your specific health & fitness goals for joining the HEALTHBREAK Fitness Center? (Check all that apply)**

❑ To lose weight
❑ To improve nutrition
❑ To improve flexibility
❑ To increase muscle mass
❑ To lower cholesterol
❑ To improve muscle tone
❑ To reduce stress
❑ To control blood pressure
❑ To improve cardiovascular fitness
❑ To feel better overall
❑ To reduce back pain
❑ Other (please specify) _____

### III. HEALTH HABIT HISTORY

Do you regard yourself as overweight? ❑ Yes ❑ No
If yes, what would you like to weigh? _____

Are you currently on a diet? ❑ Yes ❑ No
If yes list type of diet and calories per day (if known): _____

Check the description that best represents the amount of stress you experience on a daily basis?
❑ No stress ❑ Occasional mild stress ❑ Frequent moderate stress
❑ Frequent high stress ❑ Constant high stress

## IV. MEDICAL HISTORY

*Regular physical activity is safe for most people. However, some individuals should check with their doctor before they start an exercise program. To help us determine if you should consult with your doctor before starting to exercise at the State Employee Wellness Center, place a check next to all health issues, risks or problems that apply to you. The HEALTHBREAK Staff will notify you if a physician clearance is required as well as provide you with a fax request form to obtain such a clearance. All information will be kept confidential.*

**Assess your health needs by marking all true statements.**

- ❑ 1. I currently or have experienced a heart condition *(such as: Coronary Angioplasty, Heart Valve Disease, Heart Transplantation, Myocardial Infarction, Congenital Heart Disease, etc.)*
  Please describe: _____
- ❑ 2. I have had a stroke.
- ❑ 3. I am a diabetic.
- ❑ 4. I am currently pregnant.
- ❑ 5. I have been told I have asthma.
- ❑ 6. I have been told I have chronic bronchitis.
- ❑ 7. I am epileptic.
- ❑ 8. In the past month, I have experienced chest discomfort with exertion.
- ❑ 9. In the past month, I have experienced unreasonable breathlessness.
- ❑ 10. In the past month, I have experienced dizziness, fainting, and or blackouts.
- ❑ 11. I have been told that I have high blood pressure (>140/90 mm/Hg) and/or am taking blood pressure medication.
- ❑ 12. I have been told that I have high cholesterol. Level: _____ mg/dL Date of test: _____
- ❑ 13. A member of my immediate family (parents/brother/sister) has had a heart attack or stroke before age 55.
- ❑ 14. I currently smoke.
- ❑ 15. I am > 20 pounds overweight.
- ❑ 16. I am physically inactive. (I get < 30 minutes of physical activity, on < 3 days per week).
- ❑ 17. I have a bone or joint condition that is worsened with activity.
  Please describe: _____
- ❑ 18. Do you have any other health issue(s) that would limit your ability to engage in physical activity?
  If yes, please explain. _____
- ❑ 19. I am currently taking Prescription Medications. Please list:

| **Medication** | **Purpose** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**I have read, understood, and completed this questionnaire to the best of my knowledge and belief. Any questions that I had with regard to this questionnaire were answered to my full satisfaction.**

**Name: _____ Date: _____**

**Signature: _____**

*Adapted from: American College of Sports Medicine & American Heart Association Joint Position Statement, 1998.*

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Enrolled By: _____

Cleared to exercise: NO (Med release needed) Date: _____ (OR) YES Date: _____

Reason: _____ Staff Signature: _____

Resting Heart Rate: _____ bpm Resting Blood Pressure: _____/_____ mmHg

Member Referral: _____ Member Special: _____

Member ID # _____ Access Badge ID # _____

**COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING**

1570 Grant Street, Denver, CO 80203-1818 • (303) 866-2993 • (303) 866-4411 Fax • (303) 866-3883 TTY

Bill Ritter, Jr., Governor • Joan Henneberry, Executive Director

# HIPAA CONFIDENTIALITY AGREEMENT

A. The Department of Health Care Policy and Financing (the Department) is a covered entity under the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 1320d – 1320d-8 ("HIPAA") and its implementing regulations promulgated by the U.S. Department of Health and Human Services, 45 C.F.R. Parts 160, 162 and 164 (the "Privacy Rule") and other applicable laws, as amended, and is required to protect the privacy and provide for the security of the Department's protected health information (PHI). The Department is also responsible for safeguarding and protecting other confidential information under other state and federal laws; and

B. Wellness Center member, as an invitee to 1570 Grant Street, Denver, CO 80203, agrees to use only the entrance designated for wellness center members, and agrees not to enter any other floor of the building. Wellness Center member further agrees to keep confidential any PHI or other confidential information encountered on the premises.

IN WITNESS WHEREOF:

**Wellness member**

By:_____
Print Name

_____
Signature

Date: _____

**State/Covered Entity**

STATE OF COLORADO
BILL RITTER, GOVERNOR

By:_____
Legal Division Director

Date: _____

Department of Health Care Policy & Financing