TOWNSHIP of HOPEWELL

MERCER COUNTY

SENIOR SERVCIES

201 Washington Crossing Pennington Road
Titusville, New Jersey 08560-1410

Thank you for your interest in the Project Healthy Bones program. This program meets Mondays and Wednesdays at 10:30am in the Auditorium of the Hopewell Township Municipal Building.

Each class is approximately one (1) hour in length. We encourage participants to attend all the sessions. Appropriate attire for class is comfortable pants/slacks and sneakers, bring a water bottle (refillable) with you to class.

Enclosed are the following documents:

- Statement of Medical Clearance for Exercise
- Medical History
- First Session Survey

Above documents must be completed prior to the first class and returned to:

Township of Hopewell
Senior Services/Healthy Bones
201 Washington Crossing Pennington Road
Titusville, NJ 08560

PROJECT HEALTHY BONES:
MEDICAL APPROVAL FOR EXERCISE

Patient Name: _____

Address: _____

Date of Birth: _____ **Phone Number:** _____

The above named patient would like to participate in Project Healthy Bones, an exercise and educational program designed to prevent and slow the development of osteoporosis. The program is led by trained Peer Leaders.

The exercises are designed to improve balance and strength with the use of ankle and hand weights. Participants begin with 1 pound weights and progress as self-determined.

Project Healthy Bones is based on a program developed by the Massachusetts Department of Public Health and Action for Boston Community Development, Inc. in consultation with the Nutrition and Exercise Physiology Laboratory at Tufts University. The program is sponsored by the New Jersey Department of Human Services, Division of Aging Services.

For more information on Project Healthy Bones, visit www.aging.nj.gov.

_____ **YES**, I approve and support my patient's participation in this progressive weight and balance training program.

_____ **NO**, my patient is not eligible to participate in this exercise program due to his/her current medical status.

_____ _____

Physician Signature **Date**

PHYSICIAN INFORMATION:

Print Name: _____

Address: _____

_____

Telephone: _____

Please return this completed form to your patient.

PROJECT HEALTHY BONES: PARTICIPANT AGREEMENT AND RELEASE

Instructions: *Please complete, sign and date this agreement. Turn into your Peer Leader before you begin the program.*

I, _____ , understand and confirm that my
Print Full Name
participation in the Project Healthy Bones Program is completely voluntary. I agree that during my participation I will exercise at a comfortable level and will stop exercising if it becomes uncomfortable, in order to prevent any illness or injury. I hereby release the New Jersey Department of Human Services, program trainers, lead coordinators, peer leaders, the host site, and their officials, directors, members, agents, and/or employees from any liability or claims for personal injury or otherwise arising from my participation in Project Healthy Bones. I understand that my de-identified data may be used for research to measure and evaluate the effectiveness of this program.

_____ _____
Signature *Date*

Street: _____ Town: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____

EMERGENCY CONTACTS:

1. Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

2. Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

MEDICAL CONDITIONS:

Do you have any medical conditions you want your peer leaders to be aware of?

_____

_____

PROJECT HEALTHY BONES: PARTICIPANT FIRST SESSION SURVEY

Participant Name/Identifier: _____

County: _____ **Date:** _____

1. **Date of Birth:** ☐☐ ☐☐ ☐☐☐☐
   Month *Day* *Year*
2. **I am** ☐ Female ☐ Male
3. **I live alone** ☐ Yes ☐ No
4. **I am Hispanic or Latino** ☐ Yes ☐ No
5. **I am** *(check all that apply)*
   - ☐ American Indian or Alaska Native
   - ☐ Asian (country of origin): _____
   - ☐ Black or African-American
   - ☐ Native Hawaiian or Other Pacific Islander (Filipino)
   - ☐ White/Caucasian
   - ☐ Other (country of origin): _____
6. **Did you or do you have any of the following conditions?** (*check all that apply*)

   ☐ Arthritis/Rheumatic Disease ☐ Asthma ☐ Cancer
   ☐ Depression/Anxiety ☐ Diabetes ☐ Emphysema or COPD
   ☐ Crohn's or Ulcerative Colitis ☐ Osteoporosis ☐ Over-Active Thyroid
   ☐ Heart Disease ☐ Prolonged Period of Immobility
   ☐ Menopause Before Age 45 or Prolonged Absence of Your Period
   ☐ Other: _____
7. **Which of the following best describes your overall health?** (*check one*)

   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor
8. **During the <u>past month</u>, how many days did poor physical or mental health prevent you from doing your usual activities such as self-care, work or recreation**? _____ DAYS
9. **Have you fallen in the last 6 months?**

   ☐ Yes ☐ No If Yes, how many times? _____

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10. Have you fallen and gotten hurt in the past year?

☐ Yes ☐ No If Yes, how many times? _____

11. Please circle the number that best describes your level of concern about falling.

Not Worried Somewhat Worried Very Worried

0 1 2 3 4 5 6 7 8 9 10

12. Which of the following increases your concern about falling? (*check all that apply*)

☐ Going up or down stairs
☐ Tripping over rugs or clutter
☐ Walking up or down a steep incline
☐ Walking on uneven surfaces
☐ Walking on slippery or icy streets
☐ Taking medications that may cause dizziness
☐ Having poor vision or hearing
☐ Feeling unstable and losing my balance
☐ Reaching for things
☐ Not being able to get up after a fall
☐ Other: _____

13. Do you exercise regularly (30 minutes per day, 3 times per week)? ☐ Yes ☐ No

How often do you exercise?

Number of times a week: _____ Minutes each time: _____

What types of exercise do you do? (*check all that apply*)

☐ Walking ☐ Running/Jogging ☐ Dancing ☐ Aerobics
☐ Tai Chi ☐ Biking ☐ Weight Lifting ☐ Aquatics
☐ Yoga ☐ Other: _____

14. How many times have you had a bone density text (DXA)?

☐ Never ☐ One Time ☐ 2-4 Times ☐ 4 or More Times

15. What were the results of your most recent bone density text (DXA)?

☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ I Don't Know

16. Was your vitamin D concentration measured in the past year? ☐ Yes ☐ No

If Yes, what were the results?

☐ Normal ☐ Low ☐ I Don't know Level (*if known*): _____

THANK YOU!