

Fairmont State University Wellness Program

Registration Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Submission form: \_\_\_\_\_

Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Student Status:

Full-Time \_\_\_\_\_ Part-time: \_\_\_\_\_

2-year \_\_\_\_\_ 4-year \_\_\_\_\_

### Questionnaire

I am confident that I can overcome obstacles that appear in my path.	0	1	2	3	4	5	6	7	8	9	10
I am confident that I can handle anything that comes my way.	0	1	2	3	4	5	6	7	8	9	10
I am confident that I always manage to solve problems if I try hard enough.	0	1	2	3	4	5	6	7	8	9	10
I am confident in the workplace and social settings.	0	1	2	3	4	5	6	7	8	9	10
I am confident that when dealing with difficult problems and/or people.	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10
	0	1	2	3	4	5	6	7	8	9	10

### Health History

1. Do you have high blood pressure? \_\_\_\_\_
2. Do you have high cholesterol? \_\_\_\_\_
3. Do you have high triglycerides? \_\_\_\_\_
4. Do you have asthma? \_\_\_\_\_
5. Do you have diabetes? \_\_\_\_\_
6. Do you have chronic bronchitis? \_\_\_\_\_
7. Do you have emphysema? \_\_\_\_\_
8. Do you have chronic obstructive pulmonary disease? \_\_\_\_\_

### Weight Loss History

1. How many weight loss attempts have you tried in the past?  
\_\_\_\_\_
2. Were you successful at meeting your goal during those attempts?  
\_\_\_\_\_
3. Are you serious about losing weight and reaching your personal goals?  
\_\_\_\_\_

# Questionnaire

(Attach a separate piece of paper if necessary)

1. Why are you interested in participating in the Fairmont State Wellness Program?
2. Why should you be accepted into this program?
3. What are some personal goals you would like to achieve?
4. What do you think would be the best thing about being healthy?
5. What is your motivation?
6. How can we help you achieve your goals?