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, and mindfulness. We’ll help you to create a healthy body and lifestyle through lectures, discussions, interactive exercises, cooking demos, food samples, and more.

Medically Approved and Amazingly Effective

During this 6-week program our trained facilitators will help you to:

- Lose weight safely, effectively, and permanently
- Significantly reduce your 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

You’ll need to have blood work done (lipid panel and A1c) before beginning the program and again during week six. If you’ve had these tests within the last month, they can be used as the beginning tests. Some doctors will want to see you in their office before writing either or both prescriptions or before releasing the results to you or us. Please ask about your doctor’s policy ahead of time so you’re able to submit your lab results on time. You’ll need to fast for these blood tests, so getting to the lab first thing in the morning seems most practical.

Please fill out and fax the attached registration forms to our office by February 27th. It may take some time to get your doctor’s consent and the blood work results, so get on it right away.

Forms you fill out:
- Participant’s consent
- Liability release
- Questionnaire

Doctor’s forms needed:
- Physician’s consent
- Lab tests: Lipid panel and A1c results (copy)

The blood tests may be done where you choose, but your best bet is Southampton Hospital (726-8250). You are encouraged to use your insurance, but if the insurance company won’t cover it, call the contact number on your bill and let them know that you are part of the Wellness Challenge and that you would like to take advantage of their offer: each set of tests costs $30 or the combined cost of the pre- and post-program tests will be $60.

The $150 materials fee includes The Wellness Challenge Guidebook, Wellness Challenge JumpStart Guide, food for demonstrations and tastings, and other supplies. Sorry, no refunds.

Questions? Give us a call at 329-2590 or email us at info@wfeh.org. We’re always happy to help.
2015 Montauk Winter Wellness Challenge

The 2015 Montauk Winter Wellness Challenge starts March 10th. There are seven weekly sessions over the course of six weeks. Session one and session six are two hours long. The other five sessions are 1½ hours.

There’s a lot of information to cover, so try not to miss any sessions.

In case of inclement weather and school closings, your session will meet via teleconference. Please check your email for information and for call-in numbers. You may also call our office (329-2590) or visit our Facebook page (Wellness Foundation of East Hampton) for more information. For those who can’t call in for the teleconference, the call will be recorded, and you will be able to listen in at a later time.

Facilitator Zoë Klein Baxter

Montauk Montauk School
Tuesday: Start at 7:00 pm 50 S. Dorset Drive
March 10, 17, 24, 31, April 7, 14, 21, 28

Note: All of the sessions will meet at Montauk School EXCEPT the April 7th session. The school is closed for Spring Recess, so this session will meet via teleconference. If, for some reason, you can’t be on the conference call, it will be recorded, and you will be able to listen in at a later time. You will receive details from your facilitator.
Wellness Challenge Participant's Consent

Name (print) ___________________________________________ Date ____________________

First choice location ___________________ Second choice _________________________

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 your blood drawn, ask them to fax the results to us at 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
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, founder and president 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
Wellness Challenge Physician’s Consent

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 **beginning and completion prescriptions for lipid panel and hemoglobin A1c blood tests**. Completion blood tests are to be done 6 weeks from the start of the program. Giving both prescriptions at once is preferred.

On the prescription, please indicate that a copy be sent directly to the patient.

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 ___________________________________________________________
Wellness Challenge Questionnaire

The personal understanding that you will achieve by completing this questionnaire will benefit you during the program and on your future wellness journey. In addition, the information is essential for us to demonstrate the effectiveness of the program to our donors. Accordingly, the completion of the questionnaire is a requirement to graduate.

The information you provide will be used by Wellness Foundation to facilitate your progress and to establish a track record of results. The information will be kept strictly anonymous unless we obtain your approval to do otherwise.

Please complete the questionnaire except for the section entitled "Body Measurements" and the items throughout marked "On Completion," "Intention for Next Six Months," and "Accomplishments."

Legal name (print)_____________________________________________ Age ___________

Date of birth________________________________________________ Male or Female (please circle)

Profession _________________________________________________

How did you hear about the Challenge?

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

If you have already made changes to your diet 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.

List all drugs that you take, including prescription drugs, over-the-counter medications, and natural/herbal remedies. Indicate the dosage you take.

Beginning On Completion

Do you smoke and, if so, how much?

Fax your completed registration packet to 329-3714.
Incentive, Goals, and Reward
Set one principal wellness goal to be accomplished in the course of the six 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.

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Beginning</th>
<th>On Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waist measurement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LDL Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDL Cholesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Triglycerides</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemoglobin A1c</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fax your completed registration packet to 329-3714.
**Physical Conditions**
Fill in the number, on a scale of 0 to 10 (0 never and 10 always) that represents your experience.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Beginning</th>
<th>On Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congestion - head and upper respiratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore or stiff muscles or joints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartburn, acid reflux</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bloating after meals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crave sugar</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crave fat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crave salt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eat to reduce emotional pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eat to reduce day to day stress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lethargic and lack of vigor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of concentration and focus of mind</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty sleeping, waking at night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression, unpleasant mood</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Quality of life
Which best describes how you perceive your health-related quality of life?

<table>
<thead>
<tr>
<th></th>
<th>Beginning</th>
<th>On Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td></td>
<td>Excellent</td>
</tr>
<tr>
<td>Very Good</td>
<td></td>
<td>Very Good</td>
</tr>
<tr>
<td>Good</td>
<td></td>
<td>Good</td>
</tr>
<tr>
<td>Fair</td>
<td></td>
<td>Fair</td>
</tr>
<tr>
<td>Poor</td>
<td></td>
<td>Poor</td>
</tr>
</tbody>
</table>

Food & Beverage Choices
Over an average day how many servings of the following foods do you eat?

<table>
<thead>
<tr>
<th>Food &amp; Beverage Choices</th>
<th>Beginning</th>
<th>On Completion</th>
<th>Intention for Next 6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meat, including fish and poultry, eggs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dairy, including milk, butter, cheese, creamy dressings, sauces, soups, yogurt, ice cream, (i.e. cream soup = 1 serving of dairy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whole grain products (as stated on ingredients label) (all types: wheat, barley, rice, oats, quinoa, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grain products other than &quot;whole&quot;</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vegetables, fresh and frozen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fruits, fresh and frozen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nuts and seeds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Added oils in salad dressings, recipes, and for cooking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweet deserts (not included elsewhere)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy snacks (not included elsewhere)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unhealthy snacks (not included elsewhere)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Over an average day how many of the following do you consume?

<table>
<thead>
<tr>
<th>Beverage Choices</th>
<th>Beginning</th>
<th>On Completion</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasses of water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cups of caffeinated coffee or tea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholic drinks (1 drink= 5 oz. wine, 12 oz. beer, 1½ oz. liquor)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Exercise
Note the number of hours per week that you spend engaged in each activity. If you engage in an activity for less than a full hour, be sure to indicate the time accordingly, i.e. 1½ hours or ¾ hour.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Beginning</th>
<th>Completion</th>
<th>Intention for Next Six Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bike</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yoga</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strength train</td>
<td></td>
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<td></td>
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</tbody>
</table>

Stress
The Perceived Stress Scale is the most widely used psychological instrument for measuring the perception of stress. It measures of the degree to which the situations in one’s life are judged as stressful. The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

0 = Never  1 = Almost Never  2 = Sometimes  3 = Fairly Often  4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly? ................................. 0 1 2 3 4
2. In the last month, how often have you felt that you were unable to control the important things in your life? ................................. 0 1 2 3 4
3. In the last month, how often have you felt nervous and “stressed”? ............ 0 1 2 3 4
4. In the last month, how often have you felt confident about your ability to handle your personal problems? ................................. 0 1 2 3 4
5. In the last month, how often have you felt that things were going your way? ................................. 0 1 2 3 4
6. In the last month, how often have you found that you could not cope with all the things that you had to do? ................................. 0 1 2 3 4
7. In the last month, how often have you been able to control irritations in your life? ................................. 0 1 2 3 4
8. In the last month, how often have you felt that you were on top of things?... 0 1 2 3 4
9. In the last month, how often have you been angered because of things that were outside of your control? ................................. 0 1 2 3 4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? ................................. 0 1 2 3 4
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: __________________________________________________________

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.?

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 __________ Facilitator presentations ___________
Recommended books __________ Group support ___________
Overall benefit to you __________ Wellness Challenge Guidebook __________
Survival Guide for Beginners __________

Your Guidance
Please share anything else you think would help us to improve the effectiveness of the program.