HEALTH & LIFESTYLE SURVEY

NAME: _____ DATE: _____

Complete each question as best you can. Your participation is voluntary. However, to receive the most benefit from your personal report, please answer all questions.

1 Do you have a vision impairment that requires special reading materials? ◯ Yes ◯ No

2 Do you have a hearing impairment that requires special equipment? ◯ Yes ◯ No

3 What language do you prefer to speak? [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

4 Are you pregnant? ◯ Yes ◯ No ◯ Does not apply

If you answer YES to question #4, please answer the remainder of this questionnaire with pre-pregnancy information

5 Waist Circumference [ ][ ][ ] (inches, best approximation) 1. Locate your navel. 2. Hold tape end at your navel and wrap around waist. 3. Note result.

6 In the average week, how many times do you engage in physical activity (exercise or work which is hard enough to make you breathe heavily and make your heart beat faster) that is done for at least 20 minutes? Examples include running, brisk walking, or heavy labor, e.g. chopping, lifting, digging, etc.

◯ Less than 1 time per week ◯ 1 or 2 times per week ◯ 3 times per week ◯ 4 or more times per week

7 How many days per week do you get 30 minutes or more (for at least 10 minutes at a time) of light to moderate physical activity? Examples include walking, mowing (push mower), slow cycling.

◯ None ◯ 1 day ◯ 2 days ◯ 3 or 4 days ◯ 5 or 6 days ◯ 7 days

8 How many servings of food do you eat that are high in fiber, such as whole grain bread, high fiber cereal, fresh fruits or vegetables? (serving size: 1 slice bread, ½ cup vegetables, 1 medium fruit, ¾ cup cereal)

◯ 1-2 servings a day ◯ 3-4 servings a day ◯ 5-6 servings a day ◯ Rarely/never

9 How many servings of food do you eat that are high in cholesterol or fat such as fatty meat, cheese, fried foods or eggs? (serving size: 3½ oz. meat, 1 egg, 1 oz./slice cheese)

◯ 1-2 servings a day ◯ 3-4 servings a day ◯ 5-6 servings a day ◯ Rarely/never

10 How would you describe your cigarette smoking habits?

◯ Still smoke ◯ Used to Smoke ◯ Never Smoked

11 Do you smoke pipes? ◯ Yes ◯ No

12 Do you smoke cigars? ◯ Yes ◯ No

13 Do you smoke or use smokeless tobacco: chewing tobacco, snuff, nicotine patch or gum, e-cigarettes? ◯ Yes ◯ No

14 How often do you use drugs or medication (including prescription drugs) which affect your mood or help you relax?

◯ Almost every day ◯ Sometimes ◯ Rarely/never

15 How many drinks of alcoholic beverages do you have in a typical week? [ ][ ]
(one drink = one beer, glass of wine, shot of liquor or mixed drink)

16 What percentage of the time do you usually buckle your safety belt when driving or riding?

◯ 100% ◯ 90-99% ◯ 80-89% ◯ less than 80%

17 In general, how satisfied are you with your life (include personal and professional aspects)?

◯ Completely satisfied ◯ Mostly satisfied ◯ Partly satisfied ◯ Not satisfied

18 Would you agree you are satisfied with your job?

◯ Strongly Agree ◯ Agree ◯ Neutral/No Opinion ◯ Disagree ◯ Strongly Disagree

19 In general, how strong are your social ties with your family and/or friends?

◯ Very strong ◯ Above average ◯ Weaker than average ◯ Not sure

20 Considering your age, how would you describe your overall physical health?

◯ Excellent ◯ Very good ◯ Good ◯ Fair ◯ Poor

21 How many hours of sleep do you usually get at night?

◯ 6 hours or less ◯ 7 hours ◯ 8 hours ◯ 9 hours or more

22 Sleep habits

	No Chance	Slight Chance	Moderate Chance	High Chance
What is your chance of dozing while sitting or reading?	O	O	O	O
What is your chance of dozing while watching television?	O	O	O	O
What is your chance of dozing while sitting inactive in a public place (e.g., a theater or a meeting)?	O	O	O	O
What is your chance of dozing while as a passenger in a car for an hour without a break?	O	O	O	O
What is your chance of dozing while lying down to rest in the afternoon when circumstances permit?	O	O	O	O
What is your chance of dozing while sitting and talking to someone?	O	O	O	O
What is your chance of dozing while sitting quietly after lunch without alcohol?	O	O	O	O
What is your chance of dozing while in a car while stopped for a few minutes in traffic?	O	O	O	O

23 Have you suffered a personal loss or misfortune in the past year?
(For example: a job loss, disability, divorce, separation, jail term, or the death of someone close to you)

O Yes, two or more serious losses O Yes, one serious loss O No

24 Over the past two weeks, how often have you:

	None or little of the time	Some of the time	Most of the time	All of the time
Been feeling low in energy, slowed down?	O	O	O	O
Been blaming yourself for things?	O	O	O	O
Had poor appetite?	O	O	O	O
Had difficulty falling asleep, staying asleep?	O	O	O	O
Been feeling hopeless about the future?	O	O	O	O
Been feeling blue?	O	O	O	O
Been feeling no interest in things?	O	O	O	O
Had feelings of worthlessness?	O	O	O	O
Thought about or wanted to commit suicide?	O	O	O	O
Had difficulty concentrating or making decisions?	O	O	O	O

25 In the past year, how many days of work have you missed due to personal illness?

O 0 O 1-2 days O 3-5 days O 6-10 days O 11-15 days O 16 days or more

26 Check one answer per question:

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	O	O	O	O	O
How often do you have difficulty getting things in order when you have to do a task that requires organization?	O	O	O	O	O
How often do you have problems remembering appointments or obligations?	O	O	O	O	O
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	O	O	O	O	O
How often do you fidget or squirm with your hands and feet when you sit down for a long time?	O	O	O	O	O
How often do you feel overly active or compelled to do things, like you were driven by a motor?	O	O	O	O	O

27 Mark Yes or No

	Yes	No
I feel restless, keyed up or on edge.	O	O
I get tired easily.	O	O
I have trouble concentrating.	O	O
I am annoyed or irritated.	O	O
My muscles are tense and tight.	O	O
I have trouble sleeping.	O	O
Does your anxiety interfere with your daily life?	O	O

28 Have you ever had:

	Never	In the past	**Have Currently** Not Being Treated	**Have Currently** Taking Medication	**Have Currently** Under Doctor's Care
Allergies	O	O	O	O	O
Anemia Iron/ Vitamin Deficiency	O	O	O	O	O
Arthritis	O	O	O	O	O
Asthma	O	O	O	O	O
Back Pain	O	O	O	O	O
Cancer	O	O	O	O	O
Chronic Bronchitis/Emphysema/COPD	O	O	O	O	O
Chronic pain	O	O	O	O	O
Depression	O	O	O	O	O
Diabetes or Pre-Diabetes	O	O	O	O	O
Heart Disease	O	O	O	O	O
Heartburn or Acid Reflux	O	O	O	O	O
High Blood Pressure	O	O	O	O	O
High Cholesterol	O	O	O	O	O
Kidney Disease	O	O	O	O	O
Liver Disease	O	O	O	O	O
Menopause	O	O	O	O	O
Migraines	O	O	O	O	O
Osteoporosis	O	O	O	O	O
Sleep disorder	O	O	O	O	O
Stroke	O	O	O	O	O
Thyroid disease	O	O	O	O	O

29 When was the last time you had a preventive colonoscopy procedure (colon care screening)?

Less than 11 years	11 years or more	Never	Don't Know
O	O	O	O

30 When was the last time you had these preventive services or health screenings?

	Less than 1 year	1-2 years	2-3 years	3-4 years	5-6 years	7 or more or Never
Rectal exam	O	O	O	O	O	O
Flu shot	O	O	O	O	O	O
Tetanus shot	O	O	O	O	O	O
Blood Pressure	O	O	O	O	O	O
Cholesterol	O	O	O	O	O	O
Physical Exam	O	O	O	O	O	O
Dental Exam	O	O	O	O	O	O

For WOMEN Only

Preventive Pap Smear	O less than 1	O 1-2	O 2-3	O 3-4	O 5-6	O 7 or more or Never	O Not applicable (hysterectomy)
Preventive Mammogram	O less than 1	O 1-2	O 2-3	O 3-4	O 5-6	O 7 or more or Never	
Preventive Breast Exam by a physician or a nurse	O less than 1	O 1-2	O 2-3	O 3-4	O 5-6	O 7 or more or Never	

For MEN Only

Prostate exam	O less than 1	O 1-2	O 2-3	O 3-4	O 5-6	O 7 or more or Never

31 **In the past 12 months**, how many times have you:

	0 times	1-2 times	3-5 times	6 or more
Visited a physician's office or clinic	O	O	O	O
Gone to the emergency room	O	O	O	O
Stayed overnight in a hospital	O	O	O	O

32 Do you **currently** have a primary physician? O Yes O No

33 **Current** marital status **(OPTIONAL)**

O Single (never married) O Divorced O Widowed
O Separated O Married O Life Partner

34 Race/Origin **(OPTIONAL)**

O White (non-Hispanic origin) O Asian or Pacific Islander
O African-American O American Indian/Alaskan Native
O Hispanic/Latino American O Other

35 Highest level of education you have achieved **(OPTIONAL)**

O Some high school or less O College graduate
O High school graduate O Post graduate or professional degree
O Some college

36 Expected household income this year **(OPTIONAL)**

O less than $35,000 O $75,000-$99,000
O $35,000-$49,999 O $100,000 or more
O $50,000-$74,999

37 **In the next 6 months**, are you planning to make any changes to keep yourself healthy or improve your health?

	Yes	No	Don't Know	Not Needed
Increase physical activity	O	O	O	O
Lose weight	O	O	O	O
Reduce alcohol use	O	O	O	O
Quit or cut down smoking	O	O	O	O
Reduce fat/cholesterol intake	O	O	O	O
Lower blood pressure	O	O	O	O
Lower cholesterol level	O	O	O	O
Cope better with stress	O	O	O	O

38 **In the next 6 months**, would you participate in a program that would help you enhance your overall health?

O Yes O No O Don't know

Your privacy comes first! Your name and identification number are required to confirm your eligibility to take advantage of this Health Assessment. Beyond this purpose, your information is considered anonymous and is held in confidence by CHC Wellbeing and is used in aggregate, anonymous form for reporting and scientific research except with your permission.

THANK YOU FOR YOUR PARTICIPATION!

How to measure your **Waist Circumference**

1. Locate your navel.
2. Hold the end of the tape measure at your navel and bring it around your waist to the front.
3. Note the result.