

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.

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|--|--|----|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 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? | <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 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

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|----|---|---|---------------------|--------------------------|--------------------|------------------------------|---|--|--|
| 5 | Waist Circumference | <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> | | | | (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? | <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | |
| | | | | | | | | | |
| | (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
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What is your chance of dozing while sitting or reading?

What is your chance of dozing while watching television?

What is your chance of dozing while sitting inactive in a public place (e.g., a theater or a meeting)?

What is your chance of dozing while as a passenger in a car for an hour without a break?

What is your chance of dozing while lying down to rest in the afternoon when circumstances permit?

What is your chance of dozing while sitting and talking to someone?

What is your chance of dozing while sitting quietly after lunch without alcohol?

What is your chance of dozing while in a car while stopped for a few minutes in traffic?

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)

Yes, two or more serious losses

Yes, one serious loss

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
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Been feeling low in energy, slowed down?

Been blaming yourself for things?

Had poor appetite?

Had difficulty falling asleep, staying asleep?

Been feeling hopeless about the future?

Been feeling blue?

Been feeling no interest in things?

Had feelings of worthlessness?

Thought about or wanted to commit suicide?

Had difficulty concentrating or making decisions?

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

0

1-2 days

3-5 days

6-10 days

11-15 days

16 days or more

26 Check one answer per question:

Never	Rarely	Sometimes	Often	Very Often
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How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?

How often do you have difficulty getting things in order when you have to do a task that requires organization?

How often do you have problems remembering appointments or obligations?

When you have a task that requires a lot of thought, how often do you avoid or delay getting started?

How often do you fidget or squirm with your hands and feet when you sit down for a long time?

How often do you feel overly active or compelled to do things, like you were driven by a motor?

27 Mark Yes or No

Yes	No
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I feel restless, keyed up or on edge.

I get tired easily.

I have trouble concentrating.

I am annoyed or irritated.

My muscles are tense and tight.

I have trouble sleeping.

Does your anxiety interfere with your daily life?

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					
Anemia Iron/ Vitamin Deficiency					
Arthritis					
Asthma					
Back Pain					
Cancer					
Chronic Bronchitis/Emphysema/COPD					
Chronic pain					
Depression					
Diabetes or Pre-Diabetes					
Heart Disease					
Heartburn or Acid Reflux					
High Blood Pressure					
High Cholesterol					
Kidney Disease					
Liver Disease					
Menopause					
Migraines					
Osteoporosis					
Sleep disorder					
Stroke					
Thyroid disease					

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

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

Flu shot

Tetanus shot

Blood Pressure

Cholesterol

Physical Exam

Dental Exam

For WOMEN Only

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

For MEN Only

Prostate exam	less than 1	1-2	2-3	3-4	5-6	7 or more or Never
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31 In the past 12 months, how many times have you:

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

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

33 **Current** marital status (OPTIONAL)

Single (never married)	Divorced	Widowed
Separated	Married	Life Partner

34 Race/Origin (OPTIONAL)

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

35 Highest level of education you have achieved (OPTIONAL)

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

36 Expected household income this year (OPTIONAL)

less than \$35,000	\$75,000-\$99,000
\$35,000-\$49,999	\$100,000 or more
\$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
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 Increase physical activity

 Lose weight

 Reduce alcohol use

 Quit or cut down smoking

 Reduce fat/cholesterol intake

 Lower blood pressure

 Lower cholesterol level

 Cope better with stress

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

Yes	No	Don't know
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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.

