

**Health & Wellness Assessment**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**General Health**

In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

In the last 12 months, have you stayed overnight as a patient in a hospital?

- Not at all
- 1 time
- 2 or 3 times
- 4 or more times

In the last 12 months, how many times did you visit a physician or clinic?

- Not at all
- 1 time
- 2 or 3 times
- 4 to 6 times
- 7 or more times

Have you ever been told by a doctor or a health professional that you have **diabetes** or high blood sugar?

- Yes
- No

**Exercise**

How many days a week do you usually exercise?

\_\_\_\_\_ day(s) per week

On days when you exercise, for how long do you usually exercise (in minutes):

\_\_\_\_\_ minute(s) per day

How intense is your typical exercise?

- Light (like stretching or slow walking)
- Moderate (like brisk walking)
- Heavy (like jogging or swimming)
- Very heavy (like fast running or stair climbing)
- I am currently not exercising

### **Tobacco Use**

Do you currently **smoke cigarettes** or use other types of tobacco?

- Yes
- No

Are you a former smoker?

- Yes, and I quit
- No, I've never smoked

If you quit smoking, how long ago did you **quit smoking** cigarettes?

- Less than 6 months ago
- 6–11 months ago
- 1–5 years ago
- 6–10 years ago
- More than 10 years ago

Indicate below if you currently use any of these other tobacco products:

- Cigars
- Pipes
- Chewing tobacco/snuff
- I use no other tobacco products

## **Alcohol Use**

In a typical week, how many days do you drink alcohol?

\_\_\_\_\_ day(s) per week

On days when you drink alcohol, how many alcoholic drinks do you consume?

\_\_\_\_\_ drink(s) per day

In a typical week, how often do you have 5 or more alcoholic drinks on one occasion?

- Never
- Once a week
- 2–3 times per week
- More than 3 times per week

## **Nutrition**

On a typical day, how many servings of **fruits and/or vegetables** do you eat?

(1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = size of a baseball.)

\_\_\_\_\_ serving(s) per day

On a typical day, how many servings of **high fiber or whole grain foods** do you eat?

(1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)

\_\_\_\_\_ serving(s) per day

On a typical day, how many servings of **fried or high-fat foods** do you eat?

(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)

\_\_\_\_\_ serving(s) per day

## **Dental/Oral Health**

Do you have problems with your **teeth** or with chewing?

- Yes
- No

Have you seen a **dentist** within the last 12 months?

- Yes, and the date was \_\_\_\_\_.
- Yes, but I don't know the date.
- No

Do you have problems with **swallowing**?

- Yes
- No

## **Personal Safety**

Is there a friend, relative, or neighbor who would take care of you for a few days, if necessary?

- Yes
- No

Place a mark by any of the following items that you need help with:

- Dressing
- Eating
- Using the bathroom
- Grooming
- Walking
- Bathing
- Using the phone
- Transportation
- Shopping
- Preparing meals
- Housework
- Laundry
- Taking medications
- Managing money

Do you have any of the following in your home?

- Rugs in the hallway
- Poor lighting
- Pets
- Electric cords in the walking pathway

Do you have **grab bars in the bathroom**?

- Yes
- No

Do you have **stairs without handrails**?

- Yes
- No

Have you had a **fall** at home or while away from home?

- Yes
- No

### **Hearing/Vision/Memory**

Do you have any **hearing** problems?

- Yes
- No

Do you have any **vision** problems?

- Yes
- No

Do you have any **memory** problems?

- Yes
- No

## **Living Will**

Do you have a “Power of Attorney”?

- Yes, who is it? \_\_\_\_\_ . How are they related to you? \_\_\_\_\_ .
- No

Do you have a “Living Will” or Advanced Directive for Health Care?

- Yes
- No

If you do not have a “Living Will” or Advanced Directive, would you like help completing one?

- Yes
- No

## **Motor Vehicle Safety**

Do you always fasten your seat belt when you are in the car?

- Yes
- No

Do you ever drive after drinking, or ride with a driver who has been drinking?

- Yes
- No

## **Sun Exposure**

Do you protect yourself from the sun when you are outdoors?

- Yes
- No

## Mental and Emotional Health

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

- Almost all of the time
- Most of the time
- Some of the time
- Almost never

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?

- Almost all of the time
- Most of the time
- Some of the time
- Almost never

Have your feelings caused you distress or interfered with your ability to interact socially with friends?

- Yes
- No

During the past 6 months, how often have you felt sad or depressed?

- Almost all of the time
- Most of the time
- Some of the time
- Almost never

In general, how **satisfied** are you with your life?

- Very satisfied
- Satisfied
- Dissatisfied
- Very dissatisfied

How often is **stress** a problem for you?

- Never/rarely
- Sometimes
- Often
- Always

How well do you handle the **stress** in your life?

- I'm usually able to cope effectively
- At times I have problems coping
- I often have problems coping

How often do you get the **social and emotional support** you need:

- Always
- Usually
- Sometimes
- Rarely
- Never

### **Pain**

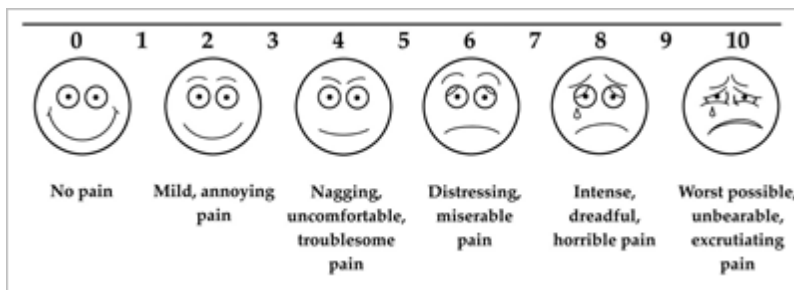
Do you have **pain**?

- Yes
- No

If you have pain, where is it located? \_\_\_\_\_

If you have pain, how bad is the pain on a scale of 1 to 10, ten being the worst pain you can imagine?

*Circle a number below.*



## **Sleep**

How many hours of **sleep** do you usually get each night?

- Less than 1 hour
- 1-3 hours
- 4-6 hours
- 7-8 hours
- More than 8 hours

## **Prevention/Screening Tests**

Have you discussed taking a **daily aspirin** with your doctor?

- Yes
- No

Have you had a **colonoscopy** within the last 5 years?

- Yes, and the date was \_\_\_\_\_.
- Yes, but I don't know the date.
- No

Have you had a **bone density test** (DXA Scan)?

- Yes, and the date was \_\_\_\_\_.
- Yes, but I don't know the date.
- No

Have you had a **flu shot** in the last 12 months?

- Yes, and the date was \_\_\_\_\_.
- Yes, but I don't know the date.
- No

Have you had a **pneumonia shot** in the last 12 months?

- Yes, and the date was \_\_\_\_\_.
- Yes, but I don't know the date.
- No

Have you ever had a **shingles shot**?

- Yes, and the date was \_\_\_\_\_.
- Yes, but I don't know the date.
- No

Have you had an **HIV test** in the past 12 months?

- Yes, and the test was positive.
- Yes, and the test was negative.
- No, but I would like to have one.
- No, but I prefer not to have one.

**Men Only:** Have you had a **prostate exam** in the last 12 months?

- Yes
- No

**Women Only:** Have you had a **mammogram** in the last 12 months?

- Yes
- No

**Women Only:** Have you had a **pap test** in the past 3 years?

List the names of any doctors, medical providers, nurses, or medical suppliers that you have:

Name	Phone	Services You Receive