CONCISE ASSESSMENT PLUS
Personal Wellness Profile

- Use a **Number 2 pencil** only.
- **Print clearly** in the boxes, and make heavy black marks, **filling the ovals completely**.
- **Erase** changes cleanly, and **do not make any stray marks**.
- **Do not fold or wrinkle** the questionnaire.
- To fill in **ID number** and **name** sections, start from the left and use only as many spaces as needed, leave the rest blank, **do not insert dashes**.

Proper Mark ●
Improper Marks ✗ ✓ ◐

NAME AND ADDRESS CLEARLY

NAME - 1st, LAST		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE	WORK PHONE	
EMAIL		
RACE		
COMPANY NAME		
PERSONAL PHYSICIAN		
INSURANCE COMPANY		
DATE TODAY – –	BIRTHDAY – –	

LAST NAME - SPACE - FIRST NAME

GENDER
① male
② female

FRAME SIZE
① small
② medium
③ large

HEIGHT ft	HEIGHT ins	WEIGHT lbs	AGE in years
	0 0	0 0 0	0 0 0
	1 1	1 1 1	1 1 1
	2	2 2 2	2 2
	3	3 3 3	3 3
4	4	4 4 4	4 4
5	5	5 5 5	5 5
6	6	6 6 6	6 6
7	7	7 7	7 7
8	8	8 8	8 8
	9	9 9	9 9

PERSONAL ID/SOCIAL SECURITY (no dashes)

GROUP ID NUMBER

QUESTIONS

1. Health view Mark any of the following that apply to you:

1. ① I'm as healthy as anybody I know.
2. ① I seem to get sick a little easier than other people.
3. ① I expect my health to get worse.
4. ① I have a serious health problem.

2. General health Complete the following statement. In general, my overall health is...

① excellent
② very good
③ good
④ fair
⑤ poor

3. Family health history Mark any of the following health problems found in your family (parent, brother, sister).

1. ① colorectal cancer
2. ① breast cancer
3. ① diabetes
4. ① coronary heart disease, heart attack, or coronary surgery before age 55 in men, before age 65 in women
5. ① high blood pressure
6. ① high blood cholesterol

4. Personal health history Has a doctor informed you that you currently have any of the following health problems? **If yes,** mark either ***yes, but not taking medication*** or ***yes, and taking medication,*** otherwise leave blank.

1 - yes, but not taking medication
2 - yes, and taking medication

1. ①② asthma
2. ①② bowel polyps or inflammatory bowel disease
3. ①② cancer, other than skin cancer
4. ①② chronic bronchitis or emphysema (COPD)
5. ①② coronary heart disease, congestive heart failure, angina, heart attack, or heart surgery
6. ①② diabetes (high blood sugar)
7. ①② high blood pressure (140/90 or higher)
8. ①② high blood cholesterol (240 or higher)
9. ①② sciatica or chronic back problem
10. ①② stroke or restricted blood flow to head or legs

5. Current symptoms Mark any of the following symptoms you have experienced within the last four weeks.

1. ① chest pain or discomfort, frequent palpitations or fluttering in the heart
2. ① unusual shortness of breath
3. ① unexplained dizziness or fainting
4. ① temporary sensation of numbness or tingling, paralysis, vision problem, or lightheadedness
5. ① frequent urination and unusual thirst
6. ① frequent back pain
7. ① have trouble sleeping lately
8. ① I've recently thought about ending my life

6. Bodily pain How much bodily pain have you had during the past four weeks?

① none
② very mild
③ mild
④ moderate
⑤ severe
⑥ very severe

7. Health limitations During the past four weeks, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health?

① none
② a little bit
③ some
④ quite a bit
⑤ could not do daily work

8. Emotional problems During the past four weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems, such as feeling depressed or anxious?

① none at all
② slightly
③ moderately
④ quite a bit
⑤ extremely

9. Social activity During the past four weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

① none at all
② slightly
③ moderately
④ quite a bit
⑤ extremely

10. Daily activities The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so how much?

1 - yes, limited a lot
2 - yes, limited a little
3 - no, not limited at all

1. ①②③ lifting or carrying groceries
2. ①②③ climbing several flights of stairs
3. ①②③ walking several blocks

11. Exercise How many days per week do you engage in aerobic exercise of at least 20 to 30 minutes duration (fitness walking, cycling, jogging, swimming, aerobic dance, active sports)?

⓪ none
① one
② two days
③ three days
④ four days
⑤ five days
⑥ six days
⑦ seven days

12. Strength exercises How many times per week do you do strength building exercises such as sit-ups, pushups, or use weight training equipment?

① none
② once a week
③ twice a week
④ three or more

13. Stretching exercises How many times per week do you do stretching exercises to improve flexibility of you back, neck, shoulders, and legs?

① none
② once a week
③ twice a week
④ three or more

14. Breakfast How often do you eat breakfast, more than just a roll and a cup of coffee?

① eat breakfast every day
② eat breakfast most mornings
③ eat breakfast two to three times per week
④ seldom or never eat breakfast

15. Snacks How often do you eat snack foods between meals (chips, pastries, soft drinks, candy, ice cream, cookies)?

① three or more times per day
② once or twice per day
③ few times per week
④ seldom or never eat typical snacks

16. Salt How often do you add salt to your food or eat salty foods (chips, pickles, soy sauce)?

① seldom or never
② some meals
③ most meals
④ nearly every meal

17. Fat intake Indicate the kinds of foods you usually eat.

High fat examples: hamburgers, hot dogs, bologna, steaks, sour cream, cheese, whole milk, eggs, butter, cake, pastry, ice cream, chocolate, fried foods, and many fast foods

Low fat examples: lean meats, skinless poultry, fish, skim milk, low fat dairy products, fruit desserts, gelatin, vegetables, pasta, legumes (peas & beans)

① nearly always eat the high fat foods
② eat mostly the high fat foods, some low fat
③ eat both about the same
④ eat mostly low fat foods, some high fat
⑤ eat only low fat foods

18. Breads and grains Indicate the kinds of breads and grains you usually eat.

Refined grain examples: white bread, rolls, regular pancakes and waffles, white rice, typical breakfast cereals, typical baked goods

Whole grain examples: whole grain breads, brown rice, oatmeal, whole grain or high fiber cereals

① nearly always eat refined grain products
② eat mostly refined grain products
③ eat both about the same
④ eat primarily whole grain products
⑤ eat only whole grain products

19. Fruits and vegetables How many servings of fruits and vegetables do you eat daily?

A serving is: 1 cup fresh, 1/2 cup cooked, 1 medium size fruit, or 3/4 cup juice

① 1 or less ③ three daily ⑤ five or more
② two daily ④ four daily

20. Number of drinks How many alcoholic drinks do you usually have **per week**?

One drink is: a 12 oz. beer, 5 oz. wine, or 1.5 oz liquor

① seldom or never ④ fifteen to twenty
② one to seven ⑤ twenty-one or more
③ eight to fourteen

21. Medications How often do you use drugs or medicines (include prescription and nonprescription) that affect your mood, help you relax, or help you sleep?

① frequently ③ rarely
② sometimes ④ never

22. Smoking status Mark the appropriate response.

① have never smoked
② quit smoking two or more years ago
③ quit smoking less than two years ago
④ smoke pipe or cigar only
⑤ currently smoke less than ten cigarettes daily
⑥ currently smoke ten or more cigarettes daily

23. Chewing tobacco Do you use chewing tobacco?

① yes ② no

24. Coping status How well do you feel you are coping with your current stress load?

① coping very well
② coping fairly well
③ have trouble coping at times
④ often have trouble coping
⑤ feel unable to cope any more

25. Stress signals Mark any item below that applies to you.

1. ① Minor problems throw me for a loop.
2. ① I find it difficult to get along with people I used to enjoy.
3. ① Nothing seems to give me pleasure anymore.
4. ① I am unable to stop thinking about my problems.
5. ① I feel frustrated, impatient, or angry much of the time.
6. ① I feel tense or anxious much of the time.

26. Feelings The next questions are about how you feel things have been with you during the past four weeks. For each question, please give the one answer that comes the closest to the way you have been feeling. How much of the time during the past four weeks...

1 - all the time
2 - most of the time
3 - a good bit of the time
4 - some of the time
5 - a little of the time
6 - none of the time

1. ①②③④⑤⑥ Have you felt calm and peaceful?
2. ①②③④⑤⑥ Did you have a lot of energy?
3. ①②③④⑤⑥ Have you felt downhearted/blue?
4. ①②③④⑤⑥ Have you been a happy person?
5. ①②③④⑤⑥ Have you felt worthless, inadequate, or unimportant?
6. ①②③④⑤⑥ Did you take the time to relax and have fun daily?

27. Sleep How often do you get 7 to 8 hours of sleep?

① always ③ less than half the time
② most of the time ④ seldom or never

28. Job satisfaction Indicate level of satisfaction.

① very satisfied ④ dissatisfied
② mostly satisfied ⑤ not applicable
③ not very satisfied

29. Social support Do you have friends/family with whom you can share problems/get help if needed?

① yes ② no

30. Seat belts How often do you wear a seat belt?

① always ③ less than half the time
② most of the time ④ seldom or never

31. Sun protection Do you use sun screen, wear protective clothing, avoid sun bathing, etc.?

① yes ② no

32. Lifting When lifting heavy objects, how often do you lift with your legs not with your back?

① always ③ less than half the time
② most of the time ④ seldom or don't know

33. Drinking and driving Do you sometimes drive when perhaps you've had too much to drink, or ride with such a person?

① yes ② no

34. Physical exam When was your last physical examination? Within the last:...

① year ③ three years ⑤ five or more
② two years ④ four years

35. Women's health issues Mark all that apply. Men skip to next question.

1. ① Currently pregnant.
2. ① Had PAP smear, within last 1-3 years.
3. ① Had mammogram within last 1-2 years.
4. ① Gave birth before reaching age 30.
5. ① Passed or reached menopause.
6. ① Taking estrogen, female hormones.
7. ① Practice monthly breast self-exam.

36. Sick days How many days did you miss from work (or from school if a student) due to illness or injury during the last 12 months?

⓪ 0 ② 2 ④ 4 ⑥ 6 ⑧ 8 ⑩ 10+
① 1 ③ 3 ⑤ 5 ⑦ 7 ⑨ 9

37. Preventive exams Mark the preventive exams you have had during the time frame listed:

1. ① bowel exam, or flexible sigmoidoscopy within last 3-10 yrs.
2. ① dental exam, within last year
3. ① flu shot, within last year

38. Readiness to change Indicate how ready you are to make the changes or improvements in your health in the following areas:

1 - no present interest in making a change
2 - plan a change in the next 6 months
3 - plan to change this month
4 - recently started doing this
5 - already do this regularly (6 mos. +)

1. ①②③④⑤ be physically active
2. ①②③④⑤ practice good eating habits
3. ①②③④⑤ avoid smoking or using tobacco
4. ①②③④⑤ lose weight, or maintain healthy weight
5. ①②③④⑤ handle stress well
6. ①②③④⑤ avoid alcohol or drink in moderation
7. ①②③④⑤ live an overall healthy lifestyle

39. Health interests Mark any of the following health improvement opportunities that you would like to be personally notified about if available.

1.	①	Quitting smoking	12.	①	Alcohol/drugs
2.	①	Weight management	13.	①	Healthy back
3.	①	Aerobics to music	14.	①	Medical self-care
4.	①	A walking group	15.	①	Stress management
5.	①	A jogging group	16.	①	CPR training
6.	①	A fitness evaluation	17.	①	First aid
7.	①	Nutrition improvement	18.	①	Health evaluation
8.	①	Cholesterol reduction	19.	①	Women's health
9.	①	Blood pressure control	20.	①	Diabetes education
10.	①	Reducing coronary risk	21.	①	Communication skills
11.	①	Cancer risk reduction	22.	①	AIDS/preventing STD
	①	Do not notify me of health promotion opportunities			

Optional Complete only if instructed to do so.

	Y	N		Y	N		Y	N
1.	①	② ③ ④ ⑤	5.	①	② ③ ④ ⑤	9.	①	② ③ ④ ⑤
2.	①	② ③ ④ ⑤	6.	①	② ③ ④ ⑤	10.	①	② ③ ④ ⑤
3.	①	② ③ ④ ⑤	7.	①	② ③ ④ ⑤	11.	①	② ③ ④ ⑤
4.	①	② ③ ④ ⑤	8.	①	② ③ ④ ⑤	12.	①	② ③ ④ ⑤

CLINICAL DATA Staff Use Only

○ mmoles use decimals, otherwise ignore decimals

Blood Pressure		Cholesterol		Glucose	Triglyceride
Systolic	Diastolic	Total	HDL	○ nonfasting	
⓪①②③④⑤⑥⑦⑧⑨	⓪①②③④⑤⑥⑦⑧⑨	⓪①②③④⑤⑥⑦⑧⑨	⓪①②③④⑤⑥⑦⑧⑨	⓪①②③④⑤⑥⑦⑧⑨	⓪①②③④⑤⑥⑦⑧⑨

Waist Girth	Hip Girth	Body Composition Test	Sum of skinfolds	Known % fat	use decim HbA1c
⓪①②③④⑤⑥⑦⑧⑨	⓪①②③④⑤⑥⑦⑧⑨	① 3-site UML ② 3-site UMM ③ 7-site ④ known % fat	⓪①②③④⑤⑥⑦⑧⑨	⓪①②③④⑤⑥⑦⑧⑨	⓪①②③④⑤⑥⑦⑧⑨

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PLEASE DO NOT WRITE IN THIS AREA

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