

Sample Well-being Assessment

This assessment addresses the following eight categories, as well as the importance, readiness, and confidence in each category:

- **Energy**
- **Stress Management**
- **Life Balance**
- **Weight**
- **Exercise**
- **Nutrition**
- **Health Issues**

Energy

Often / Sometimes / Rarely / Never: In a typical work-day, my energy is high, I am vigorous, and I am able to perform at my best.

Often / Sometimes / Rarely / Never: When not working, my energy is high, I am vigorous, and I am able to perform at my best.

ENERGY BOOSTERS – I experience the following energy boosters in my life:

- Y / N Healthy sleep
- Y / N Regular exercise
- Y / N Healthy eating habits
- Y / N Stress management, relaxation, or fun activities
- Y / N Maintaining healthy weight
- Y / N Maintaining good physical health
- Y / N Healthy mindset
- Y / N Healthy work relationships
- Y / N Healthy family and personal relationships
- Y / N Healthy finances
- Y / N Job satisfaction
- Y / N Other – describe _____

ENERGY DRAINS – I experience the following energy drains in my life:

- Y / N Poor or insufficient sleep
- Y / N Too little exercise
- Y / N Unhealthy eating habits
- Y / N Stress
- Y / N Weight management issues
- Y / N Physical health issues
- Y / N Pessimism or emotional issues
- Y / N Work relationship issues
- Y / N Family or relationship issues

Often / Sometimes / Rarely / Never: I am unable to stop thinking about my problems.

Often / Sometimes / Rarely / Never: I feel frustrated, impatient, or angry much of the time.

Often / Sometimes / Rarely / Never: I experience feelings of tension and anxiety.

Yes / No I am coping well with my current stress load.

Yes / No I have suffered a personal loss or misfortune in the past year. (For example: a job loss, disability, divorce, separation, or the death of someone close to you). If more than one loss or misfortune, indicate number: _____

Yes / No I have friends and/or family with whom I can share problems and get help if needed.

FEELINGS

Often / Sometimes / Rarely / Never: I feel calm and peaceful.

Often / Sometimes / Rarely / Never: I have a lot of energy.

Often / Sometimes / Rarely / Never: I am a happy person.

Often / Sometimes / Rarely / Never: I take the time to relax and have fun daily.

Often / Sometimes / Rarely / Never: I feel downhearted or blue.

Often / Sometimes / Rarely / Never: I feel worthless, inadequate, or unimportant.

Readiness for Change:

On a scale of 1 to 10, how ready are you to make changes or improvements in your stress levels at this time?

0 1 2 3 4 5 6 7 8 9 10

Not ready

Very ready

On a scale of 1 to 10, how important is it that you make changes or improvements in your stress levels at this time?

0 1 2 3 4 5 6 7 8 9 10

Not important

Very important

On a scale of 1 to 10, how confident are you that you can make changes or improvements in your stress levels at this time?

0 1 2 3 4 5 6 7 8 9 10

Not confident

Very confident

LIFE BALANCE

Often / Sometimes/ Rarely / Never: I maintain a comfortable balance between Work, Family, Friends and Self.

The area that I would most like to have more time for is:

- Work**
- Family**
- Friends**
- Self**

Readiness for Change:

Readiness for Change:

On a scale of 1 to 10, how ready are you to make changes or improvements in your life balance at this time?

0 1 2 3 4 5 6 7 8 9 10

Not ready

Very ready

On a scale of 1 to 10, how important is it that you make changes or improvements in your life balance at this time?

0 1 2 3 4 5 6 7 8 9 10

Not important

Very important

On a scale of 1 to 10, how confident are you that you can make changes or improvements in your life balance at this time?

0 1 2 3 4 5 6 7 8 9 10

Not confident

Very confident

WEIGHT

WEIGHT in kg (without shoes):

- _____ **Current**
- _____ **1 year ago**
- _____ **2 years ago**
- _____ **5 years ago**
- _____ **10 years ago**

WAIST TO HIP RATIO

Your body shape is an indicator of potential risks to your health. People with more weight around their waist are at greater risk of heart disease and diabetes than those with more weight around their hips.

Instructions

Divide waist circumference by hip circumference to determine your waist-to-hip ratio.

Women should ideally be below 0.8 and men below 0.9.

**I have utilized the following weight-management program(s) in the last 10 years:
(Describe)**

Readiness for Change:

On a scale of 1 to 10, how ready are you to make changes or improvements in your weight at this time?

0 1 2 3 4 5 6 7 8 9 10

Not ready

Very ready

On a scale of 1 to 10, how important is it that you make changes or improvements in your weight at this time?

0 1 2 3 4 5 6 7 8 9 10

Not important

Very important

On a scale of 1 to 10, how confident are you that you can make changes or improvements in your weight at this time?

0 1 2 3 4 5 6 7 8 9 10

Not confident

Very confident

EXERCISE

I engage (how many) **days per week** in each of the following (indicate number of days):

_____ **Aerobic** exercise – At least 20 minutes of **vigorous intensity** activity (fitness walking, cycling, jogging, swimming, aerobic dance, active sports) (3 or more days desirable) **OR** at least 30 minutes of **moderate intensity** activity (5 or more days desirable).

_____ **Strength exercises** – At least 10 minutes of strength-building exercises (such as sit-ups, push-ups, or use strength-training equipment) (2-3 days desirable)

_____ **Flexibility or stretching exercise** – At least 5 minutes to improve flexibility of your back, neck, shoulders, and legs (3 days desirable)

I currently have the following **limitations on physical activity**, if any (e.g., injuries, illness, medical conditions):

I previously had the following **limitations on physical activity**, if any, over the last 5 years:

Readiness for Change:

On a scale of 1 to 10, how ready are you to make changes or improvements in your level of exercise at this time?

0 1 2 3 4 5 6 7 8 9 10

Not ready

Very ready

On a scale of 1 to 10, how important is it that you make changes or improvements in your level of exercise at this time?

0 1 2 3 4 5 6 7 8 9 10

Not important

Very important

On a scale of 1 to 10, how confident are you that you can make changes or improvements in your level of exercise at this time?

0 1 2 3 4 5 6 7 8 9 10

Not confident

Very confident

NUTRITION

Often / Sometimes / Rarely / Never: I eat a full breakfast each day.

Often / Sometimes / Rarely / Never: I eat “junk” snack foods between meals (e.g. chips, pastries, candy, ice cream, cookies).

Often / Sometimes / Rarely / Never: I eat **high fat** food (such as hamburgers, hot dogs, bologna, steaks, sour cream, cheese, whole milk, eggs, butter, cake, pastry, ice cream, chocolate, fried foods, and many fast foods)

Often / Sometimes / Rarely / Never: I eat **low fat** food (such as lean meats, skinless poultry, fish, skim milk, low fat dairy products, fruit desserts, vegetables, pasta, legumes (peas and beans)).

Often / Sometimes / Rarely / Never: I eat **refined grain** (such as white bread, rolls, regular pancakes and waffles, white rice, typical breakfast cereals, typical baked goods)

Often / Sometimes / Rarely / Never: I eat **whole grain** (such as whole grain breads, brown rice, oatmeal, whole grain or high fiber cereals)

Often / Sometimes / Rarely / Never: I eat 5 servings of **fruits and vegetables** daily.

Often / Sometimes / Rarely / Never: I drink eight 8 glasses of **water** daily. (8 desirable)

Often / Sometimes / Rarely / Never: I drink **non-diet soft drinks** daily.

I drink (how many) **alcoholic drinks per weekday** (enter number of alcoholic drinks per weekday).

I drink (how many) **alcoholic drinks per weekend day** _____ (enter number of alcoholic drinks per weekend day).

Readiness for Change:

On a scale of 1 to 10, how ready are you to make changes or improvements in your nutrition at this time?

0 1 2 3 4 5 6 7 8 9 10

Not ready

Very ready

On a scale of 1 to 10, how important is it that you make changes or improvements in

your nutrition at this time?

0 1 2 3 4 5 6 7 8 9 10

Not important

Very important

On a scale of 1 to 10, how confident are you that you can make changes or improvements in your nutrition at this time?

0 1 2 3 4 5 6 7 8 9 10

Not confident

Very confident

HEALTH

True or False: In general, **my overall health** is excellent.

BLOOD PRESSURE:

- Systolic** (high number) (< 120 desirable)
- Diastolic** (low number) (< 80 desirable)

BLOOD LIPIDS (FASTING):

- Total cholesterol** (< 200 desirable)
- HDL** (good cholesterol) (> 40 men, > 50 women desirable)
- LDL** (bad cholesterol) (< 130 desirable)
- Triglycerides** (<150 desirable)

Yes / No: I have a **primary care doctor** whom I see regularly.

The approximate date of my **last physical exam:** _____

Women - Check all that apply:

- I am currently pregnant.
- I had PAP smear within the last 13 months.
- I had mammogram within the last 12 months.
- I practice monthly breast self-exams for lumps.

Men – Check all that apply:

- I had a prostate exam within last 12 months.
- I practice monthly testicle self-exam for lumps.

Often / Sometimes / Rarely / Never: I use drugs or medicines (include prescription and nonprescription) that treat depression, affect my mood, help me relax, or help me sleep.

PERSONAL HEALTH HISTORY – A doctor informed me that I currently have the following health problems:

Y = Yes and is not under control

C = Yes and taking medication or is under control

N = Not applicable

Y / C / N Asthma or lung disorder

Y / C / N Bowel polyps or inflammatory bowel disease

Y / C / N Cancer, other than non-melanoma skin cancer

Y / C / N Chronic bronchitis or emphysema (COPD)

Y / C / N Coronary heart disease, congestive heart failure, angina, heart attack, or heart surgery

Y / C / N Depression (mental illness)

Y / C / N Diabetes (high blood sugar)

Y / C / N High blood pressure (140/90 or higher)

Y / C / N High blood cholesterol (200 or higher)

Y / C / N Sciatica or chronic back problem (musculoskeletal)

Y / C / N Stroke or restricted blood flow to head or legs

Y / C / N Arthritis

CURRENT SYMPTOMS – I have had the following within the last month:

Chest pain or discomfort, frequent palpitations or fluttering in the heart

Unusual shortness of breath

Unexplained dizziness or fainting

Temporary sensation of numbness or tingling, paralysis, vision problem, or light-headedness

Frequent urination and unusual thirst

Frequent back pain

Trouble sleeping

Often / Sometimes / Rarely / Never: I have had bodily pain during the past month. If so, describe:

I have **missed (how many days) from work** due to illness or injury during the last 6 months: _____

Often / Sometimes / Rarely / Never: During the past month, I have had difficulty doing work, or other regular activities, as a result of my physical health.

Often / Sometimes / Rarely / Never: I smoke, If so, describe:

Appendix C – Doctor’s Release

Doctor’s Medical Release for Health, Fitness, or Wellness Coaching

Patient Name: _____

Birth Date: _____

Phone: _____

Email: _____

Please complete the following and state any contraindications or specific recommendations for your patient to participate in a health/fitness/wellness coaching program, including physical activity. The coaching program follows evidence-based guidelines for physical activity, nutrition, and weight management, developed by the American College of Sports Medicine (www.acsm.org).

Primary Risk Factors (check all that apply):

- Family History of Cardiovascular Disease
- Tobacco Use within the previous 6 months
- Hypertension
- Elevated Cholesterol
- Body Mass Index of 30 or greater
- Sedentary Lifestyle

Doctors’ Recommendations and other Patient Information:

Based on my current patient information my recommendations for the a wellness coaching program is (check one):

____ is cleared and can participate without restriction.

____ **is not cleared and cannot participate at this time.**

____ is cleared with the following restrictions:

Doctor’s Signature Date

Doctor’s Name: _____

Phone: _____

Email: _____

Clinic address: _____