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
Readiness for Change:

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

0  1  2  3  4  5  6  7  8  9  10

Not confident  Very confident

SLEEP AND STRESS

SLEEP

Often / Sometimes / Rarely / Never: I get 7-8 hours of sleep at night.

STRESS

Often / Sometimes / Rarely / Never: Minor problems throw me for a loop.

Often / Sometimes / Rarely / Never: I find it difficult to get along with people I used to enjoy.

Often / Sometimes / Rarely / Never: Nothing seems to give me pleasure anymore.
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


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
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:
Readiness for Change:

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

Not ready \hspace{1cm} \hspace{1cm} Very ready

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

Not important \hspace{1cm} \hspace{1cm} Very important

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

Not confident \hspace{1cm} \hspace{1cm} Very confident
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: ____________________________________________________