Health Risk Assessment

Name: ____________________________ Company:_______________________ Work Location:____________________

Home Address: _____________________________________ City: _____________________ State:_____ Zip:_________

DOB: _______________ Race:_________________ Gender: __M __F Employee ID:________________________

Email:____________________________________ Home Phone:___________________ Mobile:__________________

Tobacco

1. Do you smoke cigarettes, cigars or electronic cigarettes?

____Yes ____No

2. Do you use any smokeless tobacco or other nicotine products?

____Yes ____No

3. Are you frequently exposed to secondhand smoke (once weekly or more)?

____Yes ____No

Nutrition

4. How often do you eat out or get take-out?

____Never

____1-2 times per week

____3-4 times per week

____5-6 times per week

____1-2 times per day

5. How often do you skip the following meals?

	Breakfast	Lunch	Dinner
Never			
1-2 times/week			
3-4 times/week			
5+ times/week			

6. How much water do you drink? *(1 standard water bottle = ~16 oz or 2 cups)*

_____None

_____0-1 cups (8 oz) per day

_____2-4 cups per day (1-2 standard bottles of water)

_____5-8 cups per day

_____More than 8 cups per day

7. How many servings of high fiber foods do you eat daily?
(includes 100% whole grain breads and cereals, oatmeal, brown rice, whole grain pasta, fruits and vegetables, dry beans, etc.) **1 serving=1 slice bread, 1/3 cup pasta, rice, or beans; ½ cup veggies; 1 small whole fruit; ½ cup berries or sliced fruit*

_____Less than 1 serving per day

_____1-2 servings per day

_____3-4 servings per day

_____5-6 servings per day

_____7+ servings per day

8. How often do you eat *at least 5* servings of fruit and *non-starchy* vegetables? (*does not include potatoes, sweet potatoes, corn, peas, dry beans, baked beans, etc.* does includes broccoli, cauliflower, green beans, carrots, salads, tomatoes, collards, cabbage, cucumbers, mushrooms, Brussels sprouts, asparagus, peppers, onions, etc.) **1 serving=1 small piece whole fruit or ½ cup veggies or 1 cup salad greens*

_____ Less than 1 day per week

_____1-2 days per week

_____3-4 days per week

_____5-6 days per week

_____Every day

9. On an average day, how many alcoholic drinks do you consume?

_____I don't drink

_____0-1 drinks per day

_____2-3 drinks per day

_____4-5 drinks per day

_____6+ drinks per day

10. How often do you eat heavily processed or sweet foods? (includes cookies, crackers, cakes, pastries, muffins, biscuits, white bread or pasta, white rice, Lunchables, boxed mixes of pasta, rice, mac & cheese, packaged foods, salty or sweet snack foods, Nabs, etc.)

_____Less than 1 time per week

_____1-2 times per week

_____3-5 days per week

_____6-7 days per week

_____Multiple times per day

11. How many caloric beverages do you drink per day?
(includes sweet tea, soft drinks, juices, sweetened coffee drinks, fruit punch, lemonade, Gatorade, etc. – *not including diet or sugar-free drinks or alcoholic beverages*) **1 serving = 8 oz. or 1 cup; 1-20 oz. soda=2.5 servings*

_____Less than 1 per day

_____1-2 per day

_____3-4 per day

_____5-6 per day

_____7+ per day

Physical Activity

12. Does your job involve periods of sitting for more than four hours per day?

_____Yes _____No

13. How many days do you get resistance exercise for at least 30 minutes in a normal week? (ie: weight or strength training, Pilates, yoga, calisthenics)

_____Never

_____1 day per week

_____2-4 days per week

_____5+ days per week

14. How many days do you get physical activity for at least 30 consecutive minutes where your heart rate rises and you breathe heavily in a normal week?

_____Never

_____1-2 days per week

_____3-4 days per week

_____5+ days per week

Stress

15. How would you describe the stress in your daily life?

_____Minimal to none

_____Mild and tolerable

_____Moderate

_____Excessive

_____Debilitating (I've missed work or an event due to stress)

16. Are you taking positive steps to manage the stress in your life?
(ex: exercising, meditating, reading, hot bath, social support, listening to music, deep breathing, etc.)

_____Yes _____No _____Not applicable

17. Approximately how many hours of sleep do you get on a typical night?

_____Less than 5

_____Between 5 and 7

_____Between 7 and 9

_____More than 9

Medication Management

18. How often do you skip or miss a dose of a prescribed medication?

_____Never

_____1-2 times per week

_____3-4 times per week

_____5-7 times per week

_____Not applicable (ie: I'm not on any prescribed medications)

19. How many prescription medications are you prescribed to take daily?

_____None

_____1-2

_____3-4

_____5-6

_____More than 6

20. Do you take any nutritional or herbal supplements on a regular basis? *(includes fish oil, probiotics, vitamin D, calcium, iron, folic acid, protein supplements, etc.)*

_____Yes _____No

Screenings and Preventative Care

21. When was the last time you had the following screenings?

	<1 year ago	1-2 yrs ago	3-5yrs ago	>5yrs ago	Never (N/A)
Annual Physical					
Blood Pressure					
Cholesterol					
Colonoscopy (if >50 yrs) *Recommended once every 10 years after 50*					
Diabetes					
Dental Exam					
Eye Exam					
Skin Cancer					
Flu Vaccine					

Women only:

	<1 year ago	1-2 yrs ago	3-5yrs ago	>5yrs ago	Never (N/A)
Mammogram (40 or older)					
Pap smear					
Breast exam by RN or MD					

Men only:

	<1 year ago	1-2 yrs ago	3-5yrs ago	>5yrs ago	Never (N/A)
Prostate (over age 40)					

Chronic Conditions

22. Do you currently suffer from or have been diagnosed with any of the following conditions? Do you currently take any medications or supplements for any of the following conditions?

	Please mark (X) if you currently suffer from or have been diagnosed with any of the following conditions	Please mark (X) if you currently take any medications or supplements for the following conditions
Anxiety		
Asthma		
Cancer		
COPD or Emphysema		
Chronic Kidney Disease		
Congestive Heart Failure		
Coronary Artery Disease		
Crohn's Disease		
Depression		
Diabetes		
Epilepsy		
Glaucoma		
HIV/AIDS		
Irregular Heartbeat (Arrhythmia or AFIB)		
High Blood Pressure		
High Cholesterol		
Hypothyroidism		
Lupus		
Migraines		
Multiple Sclerosis		
Osteoarthritis		
Osteoporosis		
Pain, chronic		
Parkinson's		
Rheumatoid Arthritis		
Ulcerative Colitis		
Other (please specify)		

Self-Analysis

23. How do you consider your overall health?

____Excellent

____Above average

____Average

____Below average

____Poor

24. What do you think your health will be like in 10 years if you continue with your current lifestyle?

____Much better

____Better

____No different

____Worse

____Much Worse

25. How would you describe your readiness to change in the following areas?

	Not ready to change	Considering change	Ready to change	Taking action to change	No change needed
Diet/Nutrition					
Physical Activity					
Tobacco Cessation					
Weight Management					
Self-management of chronic conditions					

26. How would you describe your level of interest in the following topics?

	Extremely interested	Moderately interested	Maybe interested	Not at all interested
Diet/Nutrition				
Physical Activity				
Tobacco Cessation				
Weight Management				
Self-management of chronic conditions (ie: diabetes, high blood pressure, high cholesterol, etc.)				
Stress management				
Other Topics				