Motivation Alliance® Wellness Profile

Below is a collection of every possible question that can be included in any Motivation Alliance Wellness Profile.

Vision, Hearing and Language

Do you have a vision impairment that requires special reading materials?

□ No □ Yes

Do you have a hearing impairment that requires special equipment?
□ No □ Yes

Please select your primary language:

□ English
□ Spanish
□ French
□ German
□ Portuguese
□ Japanese
□ Chinese
□ Other

Overall Health

In general, compared to other persons my age, I would say my health is:

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Are you currently pregnant?

□ No □ Yes (If pregnant, please answer all health conditions with pre-pregnancy information)

Check all health conditions that currently apply to you:

☐ Heart Disease* (*see criteria below*)	☐ Hypertension (High Blood Pressure)
☐ Peripheral Vascular Disease	☐ Cerebrovascular Disease / Stroke
☐ Type 2 Diabetes	
☐ Type 1 Diabetes	
☐ Other Metabolic Disease (thyroid, kidney/renal, liver)	
☐ Seizure Disorders or Convulsions	☐ Any Cancer
☐ Autoimmune Disease	☐ Arthritis
☐ Asthma	☐ Pulmonary Disease (ex. cystic fibrosis, interstitial LD)
☐ Respiratory: Chronic Bronchitis or Emphysema	
☐ Any Allergies (including seasonal)	☐ Digestive Disorder
☐ Musculoskeletal problems that limit your physical activity	
☐ Chronic Back Pain	☐ Neck Pain
☐ Migraines or Severe Headaches	☐ Depression
☐ General Anxiety	☐ Mental Illness

If you selected any condition except pregnancy, continue on the next page.
Otherwise, please skip to page 6.

*Cardiovascular Heart Disease Criteria

You should select "Cardiovascular Heart Disease" if you have had:

- A heart attack
- Heart surgery
- Cardiac catheterization
- Coronary angioplasty (PTCA)
- Pacemaker / implantable cardiac defibrillator / rhythm disturbance
- Heart valve disease
- Heart failure
- Heart transplantation
- Congenital heart disease

Overall Health - Continued

Health and Productivity

If you selected one or more of the health issues from the list on the previous page, we would like to understand how your health affects your experience at work. Before starting, please take a moment to visualize your work experience for the past 2 weeks.

Think about:

- Accomplishments you might have had.
- Your work environment.
- Possible work failure.
- Your overall performance level.

Enter up to 3 medical conditions and answer the questions for each. Please respond carefully and specifically for each health issue!

☐ I am a spouse/retiree and these questions do not apply to me. (If yes, skip to page 6)

First medical condition (must be from checklist on page 2): _____

	None of the time	**A little of the time** (less than 1 hour a day)	**Some of the time** (1 - 2.9 hours a day)	**A lot of the time** (3 - 4.9 hours a day)	**Most of the time** (5 - 6.9 hours a day)	**All of the time** (7+ hours a day)
Over the past 2 weeks, how often has your condition affected the quantity (i.e. amount) of work that you do?	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has this problem caused you to not get work done while you are supposed to be working? Either because you don't feel well or because you are taking time to handle the problem.	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has your condition affected the quality of your work?	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has your condition affected your ability to concentrate?	☐	☐	☐	☐	☐	☐

☐ **Check here if you take medication for this condition**

How many days during the past 30 days have you been absent from work due to this condition? _____

(Include time away from work to see a health care provider. Use 0.5 for half days, 0.25 for a quarter day.)

Overall Health - Continued

Skip to page 6 if you do not have a second medical condition to report.

Second medical condition (must be from checklist on page 2): _____

	None of the time	**A little of the time** (less than 1 hour a day)	**Some of the time** (1 - 2.9 hours a day)	**A lot of the time** (3 - 4.9 hours a day)	**Most of the time** (5 - 6.9 hours a day)	**All of the time** (7+ hours a day)
Over the past 2 weeks, how often has your condition affected the quantity (i.e. amount) of work that you do?	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has this problem caused you to not get work done while you are supposed to be working? Either because you don't feel well or because you are taking time to handle the problem.	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has your condition affected the quality of your work?	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has your condition affected your ability to concentrate?	☐	☐	☐	☐	☐	☐

☐ **Check here if you take medication for this condition**

How many days during the past 30 days have you been absent from work due to this condition? _____
(Include time away from work to see a health care provider. Use 0.5 for half days, 0.25 for a quarter day.)

Please continue on the next page.

Overall Health - Continued

Skip to the next page if you do not have a third medical condition to report.

Third medical condition (must be from checklist on page 2): _____

	None of the time	**A little of the time** (less than 1 hour a day)	**Some of the time** (1 - 2.9 hours a day)	**A lot of the time** (3 - 4.9 hours a day)	**Most of the time** (5 - 6.9 hours a day)	**All of the time** (7+ hours a day)
Over the past 2 weeks, how often has your condition affected the quantity (i.e. amount) of work that you do?	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has this problem caused you to not get work done while you are supposed to be working? Either because you don't feel well or because you are taking time to handle the problem.	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has your condition affected the quality of your work?	☐	☐	☐	☐	☐	☐
Over the past 2 weeks, how often has your condition affected your ability to concentrate?	☐	☐	☐	☐	☐	☐

☐ **Check here if you take medication for this condition**

How many days during the past 30 days have you been absent from work due to this condition? _____
(Include time away from work to see a health care provider. Use 0.5 for half days, 0.25 for a quarter day.)

Please continue on the next page.

Cardiovascular Heart Disease Warning Signs

Check all symptoms that you have experienced:

☐ I experience chest or other muscular discomfort with light to moderate exertion, excitement or stress.* (*please see criteria below*)

☐ I have burning or cramping sensation in my lower legs when walking short distances.* (*please see criteria below*)

☐ I sometimes experience dizziness, fainting or blackouts.

☐ I experience unreasonable breathlessness or fatigue with usual activities.

☐ I sometimes experience an abnormally uncomfortable awareness of breathing while reclining or lying down.

☐ I sometimes experience rapid throbbing or fluttering of my heart (palpitations or tachycardia).

☐ I have a heart murmur.

☐ I suffer from ankle edema (swelling, perhaps most evident at night).

☐ I take medication(s) that may affect my readiness for exercise (other than blood pressure medication).

Do you have a close blood relative that had a heart attack or heart surgery before age 55 (father or brother) or age 65 (mother or sister)?

☐ Yes ☐ No ☐ Don't Know

Please continue on the next page.

*Chest or Other Discomfort Criteria

This question probes for some of the classic signs of heart disease. Such pain can be caused by Ischemia: a sign of cardiovascular impairment.

Ischemia is a shortage of blood to an organ, especially the heart. This manifests itself as angina, pain or discomfort often characterized as "constricting," "squeezing," or "burning." It may also manifest as a "heaviness" across the affected region. It usually occurs in the chest and may radiate outward to the arms and shoulders and upward to the neck, cheeks and teeth. It may also affect the far extremities (forearm and fingers) or between the shoulder blades.

Ischemia in people with coronary artery disease is often provoked by exercise or exertion, excitement, other forms of stress, in cold weather or after meals.

If you experience any of these symptoms, you should answer "Yes" to this question.

*Burning or Cramping Pain in the Legs Criteria

In asking this question, we are looking for one of the classic signs of coronary artery disease: a burning or cramping sensation in the legs referred to as Intermittent Claudication.

Intermittent claudication is caused by a shortage of blood in the legs during walking or light exercise. The pain does not occur with standing or sitting, is reproducible from day to day, and is more severe when walking uphill or up a flight of stairs. The cramp or pain will usually disappear within 1 to 2 minutes after exercise is stopped. Coronary heart disease is more prevalent in persons with intermittent claudication. Diabetics are also at increased risk.

If you experience any of these symptoms, you should answer "Yes" to this question.

Latest Blood Panel

Have you had a blood panel (cholesterol, glucose, etc.) taken in the last 3 years / since you last took this Wellness Profile? (If Yes, client is prompted to enter results)

☐ Yes ☐ No

Enter each of the requested values using the results of your most recent blood panel:
If unsure, leave at zero (0) and indicate whether your doctor offered any warnings.

Total Cholesterol

Cholesterol, in mg/dL: _____
OR: Notification from Doctor or Lab
☐ I was told my Cholesterol was too high (≥ 200 mg/dL) ☐ I was told my Cholesterol was normal ☐ Cholesterol wasn't taken or I don't remember

Medication

☐ Are you taking medicine to control your cholesterol? (check if yes)
If yes, what medicine are you taking?_____

HDL Cholesterol

HDL, in mg/dL: _____
OR: Notification from Doctor or Lab
☐ I was told my HDL was too low (Women: < 50 mg/dL – danger / Men: ≤ 40 mg/dL – danger) ☐ I was told my HDL was normal ☐ I was told my HDL was high (> 60 mg/dL is protective) ☐ HDL wasn't taken or I don't remember

LDL Cholesterol

LDL, in mg/dL: _____
OR: Notification from Doctor or Lab
☐ I was told my LDL was too high (≥ 130 mg/dL) ☐ I was told my LDL was normal ☐ LDL wasn't taken or I don't remember

Please continue on the next page.

Blood Panel - Continued

Triglycerides

Triglycerides, in mg/dL: _____
OR: Notification from Doctor or Lab
☐ I was told my Triglycerides were too high (≥ 200 mg/dL) ☐ I was told my Triglycerides were normal ☐ Triglycerides weren't taken or I don't remember

Glucose

Glucose, in mg/dL: _____
OR: Notification from Doctor or Lab
☐ My Glucose was too high or I was prediabetic / diabetic (≥ 100 mg/dL) ☐ I was told my Glucose was normal ☐ Glucose wasn't taken or I don't remember

Fasting Duration: _____ hours
Use zero (0) if you didn’t fast.

Please continue on the next page.

Latest Blood Pressure

What are your most recent (or typical) blood pressure measurements? Leave blank if unknown.

Systolic (the higher blood pressure value): _____ mmHg

Diastolic (the lower blood pressure value): _____ mmHg

Are you taking medicine to control your blood pressure?

☐ Yes ☐ No

If yes, what medicine are you taking?_____

Current Weight, Height and Abdominal Measurement

Please enter weight, height and waist values

What is your current weight? _____ lbs

How tall are you? _____ ft _____ inches

Abdominal Circumference*: _____ inches

*Taking an "Abdominal" Measure

The abdominal measurement should be taken midway between the last rib and the top of the hips - right about at the naval. This will be the widest point of your abdomen. If you haven't taken this measurement, please either do so now (it is really valuable) or leave this value blank. Do not estimate by using waist values from clothing.

Do you consider yourself: ☐ Overweight ☐ Underweight ☐ Just About Right

Please continue on the next page.

Medical Practices

When did you last receive the following types of care?

	Last 6 Months	**6-12 Months**	**1-2 Years**	**2+ Years**	**Never**
See a doctor for a physical?	☐	☐	☐	☐	☐
See a dentist for an exam?	☐	☐	☐	☐	☐
Have your blood pressure checked?	☐	☐	☐	☐	☐
Have your cholesterol checked?	☐	☐	☐	☐	☐
Have you had a flu shot in the last year?	☐ No ☐ Yes				
Have you had a pneumonia shot?	☐ No ☐ Yes				
Have you had a shot for Zoster/shingles?	☐ No ☐ Yes				
When did you last have a colonoscopy?	☐	☐	☐	☐	☐
Questions for Men	**Last 6 Months**	**6-12 Months**	**1-2 Years**	**2+ Years**	**Never**
When did you last have a prostate exam?	☐	☐	☐	☐	☐
Do you practice monthly testicular exams?	☐ No ☐ Yes				
Questions for Women	**Last 6 Months**	**6-12 Months**	**1-2 Years**	**2+ Years**	**Never**
When did you last have a pap smear?	☐	☐	☐	☐	☐
When did you last have a mammogram?	☐	☐	☐	☐	☐
Do you practice monthly breast exams?	☐ No ☐ Yes				

Please continue on the next page.

Recent Medical Services / Other and Absenteeism

In the past 12 months, how many times have you visited your physician?

☐ No visits ☐ 1-2 Visits ☐ 3-5 Visits ☐ 6-9 Visits ☐ 10 or More

In the past 12 months, how many times have you been admitted to the hospital?

☐ None ☐ Once ☐ Twice ☐ Three times ☐ 4 Times or More

In the past 12 months, how many times have you been admitted to the emergency room?

☐ No ER Admissions ☐ Once ☐ Twice ☐ Three times ☐ 4 Times or More

Have you had major surgery or a hospitalization within the last six months?

☐ No ☐ Yes

Have you missed more than 5 days of work or school in the past year due to illness?

☐ No ☐ Yes

Have you missed more than 5 days of work or school in the past year due to illness?

☐ No ☐ Yes

Please continue on the next page.

Family History

Do you have a family history of stroke?

☐ Yes

☐ No

☐ I don’t know

Do you have a family history of cancer?

☐ Yes

☐ No

☐ I don’t know

Do you have a family history of diabetes?

☐ Yes

☐ No

☐ I don’t know

Do you have a family history of high cholesterol?

☐ Yes

☐ No

☐ I don’t know

Do you have a family history of high blood pressure?

☐ Yes

☐ No

☐ I don’t know

Please continue on the next page.

Physical Activity and Exercise

In a typical week, how often do you engage in exercise, work or other activities that at least moderately increase your breathing and heart rate for 30 minutes or more?

☐ 5 or more times per week

☐ 3-4 times per week

☐ 1-2 times per week

☐ Less than 1 time per week

☐ Seldom or never

If you exercise at least 3 times per week, how long have you maintained such an active lifestyle? *If you don't exercise at least 3x per week, select "Not applicable".*

☐ Not applicable (I am not active)

☐ Less than 1 year

☐ 1-2 years

☐ 2-5 years

☐ More than 5 years

In a typical week, how many minutes do you engage in vigorous activity?
(e.g. jogging or running, swimming laps, riding a bike fast or uphill, playing basketball, etc.)

☐ minutes

In a typical week, how many minutes do you engage in moderate activity?
(e.g. walking fast, water aerobics, pushing a lawnmower, riding a bike on level ground, etc.)

☐ minutes

Please continue on the next page.

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?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐	☐	☐
Lifting or carrying groceries	☐	☐	☐
Climbing several flights of stairs	☐	☐	☐
Climbing one flight of stairs	☐	☐	☐
Bending, kneeling, or stooping	☐	☐	☐
Walking more than a mile	☐	☐	☐
Walking several blocks	☐	☐	☐
Walking one block	☐	☐	☐
Bathing or dressing yourself	☐	☐	☐
Shopping	☐	☐	☐
Managing medications	☐	☐	☐
Managing finances	☐	☐	☐

Do you have musculoskeletal problems in your hips or knees that limit your ability to exercise?

☐ No ☐ Yes

Do you have concerns about the safety of exercise or know of other reasons why exercise might present a greater risk?

☐ No ☐ Yes

Please continue on the next page.

Diet

How often do you eat breakfast?

☐ Almost every day ☐ Sometimes ☐ Rarely or never

On average, how many servings of fruit do you eat per day?
(One serving= 1 banana, 1 large orange, 1 small apple, 1 cup of 100% fruit juice, 1 cup of chopped or sliced fruit, or ½ cup dried fruit)

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

On average, how many servings of vegetables do you eat per day?
(One serving= 1 cup of raw or cooked vegetables, 2 cups of raw leafy greens, or 1 cup 100% juice)

☐ None ☐ 1-2 ☐ 3 ☐ 4 ☐ 5 or more

On average, how many servings of bread, cereal, rice or pasta do you eat per day?
(One serving= 1 slice bread, 1 cup of ready-to-eat cereal, ½ cup of cooked rice, cooked pasta, or cooked cereal)

☐ None ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ 10 or more

When you use grain and cereal products, do you emphasize:

☐ Whole grain, high fiber ☐ A mixture of whole grain and refined ☐ Refined, low fiber

On average, how many servings of red meat (not lean) do you eat per day?
(One serving=2-3 ounces of steak, roast beef, lamb, pork chops, ham, hamburgers, etc)

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

On average, how many servings of fish, poultry, lean meat, cooked dry beans, peanut butter, or nuts do you eat per day?
(One serving= 1 ounce of lean meat, poultry, or fish, ¼ cup of cooked beans, 1 egg, 1 tablespoon of peanut butter, ½ ounce of nuts or seeds)

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

On average, how many servings of dairy products do you eat per day?
(One serving=1 cup of milk or yogurt, 1.5 ounces of natural cheese, 2 ounces of processed cheese)

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Diet - Continued

When you use dairy products, do you emphasize:

☐ Regular (full fat) ☐ Low-fat ☐ Skim (Non-fat)

How would you characterize your intake of fats and oils?
(including fatty meats, full-fat milk, regular salad dressings, butter or margarine, mayonnaise, vegetable oils)

☐ High ☐ Moderate ☐ Low

How would you characterize your overall eating habits?

☐ Very healthy ☐ Healthy ☐ Average ☐ Fair ☐ Poor

I eat fresh, nutrient-dense foods in moderate quantities while avoiding empty calories:

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

I eat at least five servings of fruits and vegetables every day:

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

I avoid sugary drinks and juices:

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

I eat mindfully without distraction from phone or TV:

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

I eat reasonably sized portions:

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

I eat to relieve stress, unhappiness or other emotions:

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

I avoid 'junk' carbs such as cookies, pie, cake, candy, etc.:

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

Please continue on the next page.

Tobacco Use

How would you describe your tobacco use?

☐ Never smoked ☐ Currently smoke ☐ Smoke and use chewing tobacco
☐ Quit smoking two or more years ago ☐ Use chewing tobacco
☐ Smoke pipe or cigar only ☐ Quit smoking less than two years ago

Alcohol Use

During a typical week, how many alcoholic drinks do you consume?
(A "drink" is a glass of wine, a wine cooler, a bottle/can of beer, a shot glass of liquor, or a mixed drink.)

☐ Never use alcohol ☐ 1-6 per week ☐ More than 2 per day / 14 per week ☐ Less than 1 per week ☐ 1-2 per day / 7-14 per week

Over the last month, how many times (if any) have you had five or more drinks on one occasion?

☐ None ☐ Once ☐ Twice ☐ Three to five times ☐ Six times or more

Medication Use

How often do you have trouble taking medication the way you have been advised by your provider?

- ☐ I am not on any prescribed medication
- ☐ I always take my prescribed medication
- ☐ Sometimes I take my prescribed medication
- ☐ I do not take my prescribed medication
- ☐ I take prescription medication that have not been prescribed to me

How would you characterize your use of medications or other drugs to help you relax?

☐ Seldom or never ☐ Less than once a week ☐ 1-3 times per week ☐ 4+ times per week

Please continue on the next page.

Driving Habits

When driving or riding in a car, do you wear a seat belt:

☐ All or most of the time ☐ Some of the time ☐ Once in a while ☐ Rarely or never

When driving or riding in a motorcycle, do you wear a helmet (choose "All or most of the time" if you don't ride a motorcycle):

☐ All or most of the time ☐ Some of the time ☐ Once in a while ☐ Rarely or never

Psychological Health, Sleep, Social and Spiritual Health

How have you been feeling, in general, during the past month?

☐ In excellent spirits ☐ In good spirits mostly ☐ In low spirits mostly

☐ In very good spirits ☐ I've been up and down in spirits ☐ In very low spirits

How would you rate your overall life satisfaction?

☐ Not Satisfied ☐ Partly Satisfied ☐ Mostly Satisfied ☐ Very Satisfied

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities as a **result of any emotional problems** (such as feeling depressed or anxious)?

	Yes	No
Cut down the amount of time you spent on work or other activities?	☐	☐
Accomplished less than you would like?	☐	☐
Didn't do work or other activities as carefully as usual?	☐	☐

How would you rate your overall satisfaction with your work?

☐ Not Satisfied ☐ Partly Satisfied ☐ Mostly Satisfied ☐ Very Satisfied

On average, how many hours of sleep do you get in a 24-hour period?

☐ A lot ☐ A moderate amount ☐ Relatively little ☐ Almost none

Please continue on the next page.

Psychological Health, Sleep, Social and Spiritual Health Con.

How often do you get insufficient rest so that you are unable to function efficiently?

☐ Less than weekly ☐ Usually 1 night per week

☐ 2 to 3 nights per week ☐ 4 or more nights per week

How many friends and relatives (including your spouse) do you feel close to?

☐ 10 or more ☐ 5 to 9 ☐ 1-4 ☐ none

In general, how strong do you feel your social ties are with your family and friends?

☐ Very strong ☐ About average ☐ Weaker than average

During **the past 4 weeks**, to what extent has your **physical health or emotional problems** interfered with your normal social activities with family, friends, neighbors, or groups?

☐ Not at all ☐- Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

How would you describe your spiritual health? (Defined as the ability to discover, articulate and act on one's own purpose in life; to learn how to give and receive love, joy, and peace; and to help improve the spiritual health of others.)

☐ Good to excellent ☐ Fair to poor ☐ Very poor

Please continue on the next page.

Stress

During the past month, how much stress have you experienced?

☐ A lot ☐ A moderate amount ☐ Relatively little ☐ Almost none

In the past year, how much effect has stress had on your health?

☐ Hardly any or none ☐ Some ☐ A lot

Readiness For Change

Note: being 'active' means that you exercise or engage in physically demanding work at least 3 times per week.

Which statement describes your attitude towards exercise and an 'active' lifestyle the best:

☐ I am presently active and don't need to make changes.

☐ I have recently begun a program of exercise but still face the obstacles selected below.

☐ I am ready to commit to a program of exercise but face the obstacles selected below.

☐ I am thinking about being more active but am not ready to commit to the changes required.

☐ Exercise may be beneficial but I am not seriously considering a commitment at this time.

Which of these obstacles to an active lifestyle, if any, apply to you?

☐ I have no time

☐ Friends & family are not supportive

☐ I don't know where to start

☐ I lack room, resources or equipment

☐ I find exercise unpleasant

☐ I worry that I am not medically able

☐ I find 'gyms' intimidating

☐ I feel somewhat embarrassed

☐ I am recovering from an injury

☐ Other

Please continue on the next page.

Which statement describes your attitude towards weight management / weight loss the best?

☐ My weight is healthy: I do not need a weight management program.

☐ I am currently working toward a healthier weight but still face the obstacles selected below.

☐ I am ready to begin a program of weight management but face the obstacles selected below.

☐ I am thinking about trying to lose weight but am not ready to commit to the changes required.

☐ Losing weight might be beneficial but I am not seriously considering a commitment to weight loss at this time.

Which of these weight management obstacles, if any, apply to you?

☐ Lack of knowledge about weight management

☐ Lack of access to low-calorie or healthy foods

☐ Family or social group won't like or support a change

☐ Lack of access to exercise opportunities

☐ Eating helps me cope with stress so restricting foods could make my life more stressful

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Which statement best describes your attitude toward a healthy diet?

☐ My diet is healthy: I don’t need to make dietary changes.

☐ I am currently eating a healthier diet but still face the obstacles selected below.

☐ I am ready to commit to an improved diet but face the obstacles selected below.

☐ I am thinking about improving my diet but am not ready to commit to the changes required.

☐ An improved diet might be beneficial but I am not seriously considering dietary changes at this time.

Which of these obstacles to a healthier diet, if any, apply to you?

☐ Lack of knowledge about finding or preparing healthier food

☐ Time needed to prepare healthy foods

☐ Family or friends won't support a change in diet

☐ I don't like most 'healthy' foods

☐ ‘Healthy’ foods are too expensive

☐ Other obstacle

Please continue on the next page.

Readiness For Change - Continued

With respect to tobacco, which statement describes your attitude toward change best?

☐ I do not smoke or use tobacco: I don't need to make changes

☐ I recently quit smoking or using tobacco but still face the obstacles selected below

☐ I smoke or use tobacco. I am ready to quit but face the obstacles selected below

☐ I smoke or use tobacco and often think about quitting. However, I am not yet ready to commit to the changes required

☐ I smoke or use tobacco. While quitting may be beneficial, I am not seriously considering it at this time

If you use tobacco, which of the following obstacles to quitting apply to you?

☐ I don't know where to begin

☐ Smoking helps me cope with stress

☐ My friends or family smoke

☐ I'm afraid that I'll gain weight

☐ It is difficult to avoid the temptation

☐ Other reasons make it difficult to quit smoking

Please continue on the next page.

Readiness For Change - Continued

With respect to alcohol use, which statement describes your attitude toward change best?

☐ I do not drink alcohol to excess: I don't need to make changes

☐ I have recently stopped/reduced drinking but still face the obstacles selected below

☐ I am ready to stop or reduce my drinking but face the obstacles selected below

☐ I sometimes think that drinking less might be beneficial but am not ready to commit to the changes required

☐ I sometimes think that drinking less might be beneficial but I am not seriously considering change at this time

If you wish to reduce or stop drinking alcohol, what are your principle obstacles?

☐ I don't know where to begin

☐ It is difficult to avoid the temptation to drink

☐ Alcohol is part of many of my social situations

☐ Friends would treat me as an 'alcoholic' with a problem if I stopped

☐ Alcohol helps me cope with stress so giving it up could make my life more stressful

☐ Other reasons make it difficult to stop or reduce drinking

THANK YOU FOR COMPLETING YOUR ASSESSMENT.