

General Health Assessment



This assessment will ask you about your health and lifestyle habits. You will receive a report with information about your health risks, healthy and unhealthy habits, and risk reduction strategies. This health risk assessment is not intended to diagnose any diseases, illnesses or health conditions.

The information obtained from this assessment will be stored in the most secure manner that technology allows. None of your personal data will be released to anyone without your prior approval. TRALE will only use your data to be combined with others in a large database for aggregate reporting back to your employer. This will allow your employer to improve overall employee health through offering specific interventions.

Please fill in your responses like this using a No. 2 Pencil ...

1. What is your gender?

Male Female

2. What is your age?

0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9

3. What is your ethnic origin?

3. Ethnic Origin

- African American
 American Indian or Alaskan Native
 Asian or Pacific Islander
 Hispanic
 White
 Other

4. If you had to rate your current state of health, how would you answer?

4. State of Health

- Great
 Good
 Average
 Below Average
 Poor

5. What is your job class?

5. Job Class

- Management Field/Office Office Staff
 Carpenter/Welder Laborer
 Shop/Maintenance Operator

PLEASE PRINT

Name _____
 Street Address _____
 City _____ State _____ ZIP Code _____
 Email _____
 Company _____

Tobacco

6. Do you smoke cigarettes?

- Yes, I currently smoke cigarettes
 I quit smoking 2 or more years ago
 I quit smoking less than 2 years ago
 I have never smoked cigarettes

7. If you marked that you currently smoke cigarettes, please enter the total number of cigarettes you smoke in an average day.

0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9

8. How many cigars or pipes do you smoke per day?

- None 1 or less 2 or more

9. How many times a day do you use smokeless tobacco (snuff or chewing tobacco)?

- None 1 or less 2 or more

Nutrition

10. How many servings do you eat from the following food groups?

		NONE	1-4 PER WEEK	5-7 PER WEEK	2 PER DAY	3+ PER DAY
Fruits:	1 medium piece (tennis ball) or ½ cup chopped (½ baseball)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables:	1 cup raw or ½ cup cooked (½ baseball)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Protein:	meat, chicken, nuts, beans (½ deck of cards)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Complex carbohydrates:	whole wheat bread, brown rice, whole grain cereal (1 slice/ cooked-½ baseball)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simple carbohydrates:	white bread, white rice, processed cereal, pasta (1 slice/ cooked-½ cup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy:	milk, cheese, yogurt (1 cup milk, a slice of cheese, 1 cup yogurt)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Processed meats:	hot dogs, lunch meats, bacon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried foods:	french fries, fried chicken, chips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fats:	cream, butter, sauces, shortening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweets & desserts:	cookies, cake, donuts, candy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2264

2264

Vehicle Safety

- Never Two or more
 - Once
 - Never 0% Usually 80-99%
 - Seldom 1-39% Always 100%
 - Sometimes 40-79%
 - Within 5 miles per hour 11-20 mph over
 - 6-10 mph over More than 20 mph over
11. How many times in the last month did you drive or ride when the driver had perhaps too much alcohol to drink?
12. What percentage of the time do you buckle your safety belt when either driving or riding in a motor vehicle?
13. On the average, how close to the posted speed limit do you usually drive?

Physical Activity

- 6 - 7 days a week 1 day a week
 - 4 - 5 days a week Never
 - 2 - 3 days a week
14. How many days a week do you do at least 20-30 minutes of physical activity, without stopping, in which you breathe heavier and your heart beats faster?

Alcohol

- None, I don't drink alcohol 8 - 14 drinks
 - 1 - 2 drinks 15 or more drinks
 - 3 - 7 drinks
 - Yes No
15. In an average week, how many alcoholic drinks do you consume?
16. If you drink alcohol, do you ever drink more than 5 drinks at a time?

Stress & Depression

- | | RARELY | SOMETIMES | OFTEN | ALMOST ALWAYS | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 17. At any time in the past year, how often have you felt: |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Downhearted or sad? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angry or hostile? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous or uptight? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | That you are receiving good support from friends and family? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | That interesting and challenging situations fill your life? |

- | | NONE | A LITTLE | SOME | A LOT | OVER-WHELMING | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 18. How much stress do you feel in these areas of your life? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Work / Job |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Family |

- I am very effective I am not effective
 - I am somewhat effective I try to manage my stress but it doesn't seem to help
19. Do you feel you are effective in managing the stress in your daily life?

Current Health

- | | YES | NO | TAKING MEDICATION | |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 20. Do you currently have or have you ever had any of the following?
<i>(If you answered yes, please indicate if you are taking medication for it.)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Back Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer (of any kind) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Polyps of the Colon or Rectum |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Bronchitis or Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | New/Chronic Neurologic Issues of Extremities |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angina, Congestive Heart Failure or Heart Attack |

Medical Care

21. Do you have a primary care doctor or health care provider? Yes No
22. Have you had or do you have scheduled a routine physical in the past or future 12 months? Yes No
23. Do you have a medical condition that will require use of the healthcare system in the next year? Yes No
24. How confident are you with your ability to do the following?
- | | NOT CONFIDENT | | NEUTRAL | | CONFIDENT |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Understand your healthcare benefits | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Talk with your doctor | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Care for a minor illness or injury | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Women's Health - MEN GO TO QUESTION 31

25. Are you currently pregnant? Yes No
26. How often do you do a self-administered breast exam to check for lumps? Monthly Rarely or never
Once every few months
27. When did you last have your breasts examined by a physician or nurse? Within the past year More than 3 years ago
1 to 2 years ago Never
2 to 3 years ago
28. When did you last have a Pap Smear? Within the past year More than 3 years ago
1 to 2 years ago Never
2 to 3 years ago
29. When did you last have a digital rectal exam? (Answer only if you are age 40 or over) Within the past year More than 3 years ago
1 to 2 years ago Never
2 to 3 years ago
30. When did you last have a Mammogram (breast x-ray)? (Answer only if you are age 40 or over) Within the past year More than 3 years ago
1 to 2 years ago Never
2 to 3 years ago

Men's Health

31. When did you last have a rectal or prostate exam? (Answer only if you are age 40 or over) Within the past year More than 3 years ago
1 to 2 years ago Never
2 to 3 years ago
32. How often do you examine your testicles for lumps? Monthly Rarely or never
Once every few months

Readiness to Change

33. Are you currently planning to make any changes to keep yourself healthy or improve your health?
- | | YES, IN THE NEXT 30 DAYS | YES, IN THE NEXT 6 MONTHS | I HAVE RECENTLY MADE A HEALTHY CHANGE | I AM ALREADY MAINTAINING HEALTHY HABITS | NOT INTERESTED |
|--------------------|--------------------------|---------------------------|---------------------------------------|---|--------------------------|
| Diet and Nutrition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco Use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Management | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stress | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcohol Use | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

MEMBER INTEREST SURVEY
How well do we communicate?

- 1) ESHCA Wellness offers a monthly online newsletter, *Wellness: 2020 Vision*. It provides information to members regarding incentive programs, health/wellness and financial fitness. In 2020, it will also be offered as a cell phone text link.

Please check all that apply:

- I already receive the newsletter through email and that works for me.
- Please include me in a cell phone text link, my cell phone number is: _____
- I am not interested in receiving the online newsletter.

Please note, your contact information is never shared with anyone. The information is sent one time per month, meaning you will not receive excessive emails or text notifications. Each month you are given the option to "stop" notifications.

- 2) Are you aware of the \$200 Annual Physical Incentive offered by ESHCA?

- Yes, I submitted my paperwork and received the \$200 incentive.
- Yes, but I did not submit the paperwork to receive the \$200 incentive.
 - I do not know how.
 - I am not interested in receiving the incentive.
- No, I am not aware of the incentive.

- 3) Two times per year, information is mailed outlining the Wellness Program and its incentives. Is it effective?

- Yes, I have received it and read through the information.
- Yes, I received the information but did not review it.
- No, I do not recall receiving that information.

- 4) I would be interested in more information or programs in relation to:

Check all that apply:

- Health Insurance and how it works
- Medical conditions such as high blood pressure, high cholesterol, high blood sugar, etc.
- Nutrition
- Exercise
- Finances
- Other: _____