Healthy Foundations Assessments

Important Note

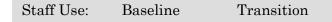
To complete this assessment electronically:

- 1. Download and save the file to your computer.
- Open, complete and save the form in the Adobe Acrobat Reader program.
 (DO NOT complete the form in an Internet browser. Your information may not save.)
- 3. When done attach the PDF to an email and return to your Healthy Foundations contact.

Member Name:_____

Date:_____

The following assessments serve as a learning tool for you and the Healthy Foundations team. Please select the best response as it relates to you on a typical day. Information is only reported at an aggregate level and your responses will remain anonymous.





Healthy Foundations Member Enrollment Form

Your name (Las	t, First, Middle):]	Date:
Preferred name	(if applicable):			DOB: _	
Gender:	Preferred Prono	un:			
Your address: _					
City:		State:	Zip co	ode:	
Preferred phone	9:	□Home	□Cell	□Work	
_	•				
Occupation:					
Your ethnicity:	□Hispanic/Latino OR	\Box Not Hi	ispanic/La	tino	
Your race:	□American Indian or Ala	askan Nativ	е		
	□Asian				
	□Black or African Ameri	ican			
	□Native Hawaiian/Othe	r Pacific Isla	nder		
	□White				
	□Other:				
	□Prefer to not answer				
Your preferred	language:				

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Health Overview

1. What health conditions do you live with? Please check all that apply:

Diabetes Type 1	High Cholesterol	High Blood Pressure
Diabetes Type 2	Chronic Obstructive Pulmonary Disease	_Sleep Apnea
Asthma	Heart Disease (or other cardiac condition) _	Depression
Anxiety	Spine and/or joint pain	
Other:		

2. What medications and supplements do you take (name, reasoning, dosing/frequency)?

Medication:	Medication:
Reasoning:	Reasoning:
Dosing/frequency:	Dosing/frequency:
Medication:	Medication:
Reasoning:	Reasoning:
Dosing/frequency:	Dosing/frequency:
Medication:	Medication:
Reasoning:	Reasoning:
Dosing/frequency:	Dosing/frequency:

Additional space: _____

- 3. What are your allergies? (including medication allergies):______
- 4. Do you sometimes consume: alcoholic beverages? Yes \Box No \Box recreational drugs? Yes \Box No \Box

If yes to above: Do you feel you need to cut back or quit?



5. Do you use to bacco products? Yes $\Box~$ No $\Box~$

If yes to above: Are you intere	sted in information on quitting? Yes \Box No \Box			
6. What prior surgeries have you had, and	when?			
Surgery:	Date:			
Surgery:	Date:			
Surgery:	Date:			
Additional space:				
8. What clinic is your primary care provider Are you satisfied with the care you re	r with? (if any) ecceive from your primary care provider? Yes □ No □			
9. What other doctors or providers do you so	-			
Provider name:				
Provider name:				
Provider name:	Specialty:			
10. What health conditions run in your famil grandparents)?	ly (your siblings, parents, children, or			
Health condition:	_ Family member:			
Health condition:	_ Family member:			
Health condition:	_ Family member:			
Health condition: Family member:				
Additional space:				

11. Do you have an advanced directive? Yes \Box $\,$ No $\,$



Staff Use: Baseline Transition

Work Questionnaire

Absenteeism

How many days within the last 3 months have you missed work due to illness or injury?

0-3 4-7 8-11 12-15 15+

How many days within the last 3 months have you missed work due to Short Term Disability or Long Term Disability?

0-3 4-7 8-11 12-15 15+

Productivity

In thinking about your productivity at work over the last 4 weeks, have you been MORE, LESS, or EQUALLY PRODUCTIVE?

More productive Less productive Equally productive

Work-life balance

In thinking about your work life balance over the last 4 weeks, have things been BETTER, WORSE, or THE SAME?

Better Worse The same



Your Name (please print):_____

Date:_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Several	More than	Nearly
Select the number (0-3) corresponding with your response.	Not at all 0	days 1	half the days 2	every day 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?		Not difficult at all: 0	Somewhat difficult: 1	Very difficult: 2	Extremely difficult: 3
Staff Use:	Total of each column:				

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.



Your Name (please print)

Date _____

Perceived Stress Scale (PSS)

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you are being asked to indicate *how often* you felt or thought a certain way. Please read each question carefully and select your answer.

0 = Never	1 = Almost Never	2 = Sometimes	3 = Fairly	Oft	en	4	= Ve	ery Of	ten
	month, how often have yo important things in your			0	1	2	3	4	Staff Use:
	month, how often have yo ar personal problems?			0	1	2	3	4	
	month, how often have yo our way?			0	1	2	3	4	
	month, how often have yo p so high that you could n			0	1	2	3	4	Score:

The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). Mind Garden, Inc.

Adherence to Medication Assessment Survey

	Staff Use:	Baseline	Transition	
V N (.l		D		
Your Name (please print)		D	ate:	

		Motivation Quadrant	Knowledge Quadrant
1)	Do you ever forget to take your medicine?	Yes (0 point) No (1 point)	
2)	People sometimes miss taking their medicines for reasons other than forgetting. Are there days when you do not take your medicine?	Yes (0 point) No (1 point)	
3)	When you feel better, do you sometimes stop taking your medicine?		Yes (0 point) No (1 point)
4)	Sometimes, if you feel worse when you take your medicine, do you stop taking it?		Yes (0 point) No (1 point)
5)	Do you know the long-term benefit of taking your medicine as told to you by your doctor or pharmacist?		Yes (1 point) No (0 point)
6)	Sometimes do you forget to refill your prescription medicine on time?	Yes (0 point) No (1 point)	
Staff U	Jse:	Questions 1+2+6=	Questions 3+4+5 =



Name (please print):

Date:

DAILY ACTIVITIES

During the past 4 weeks...

How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health?

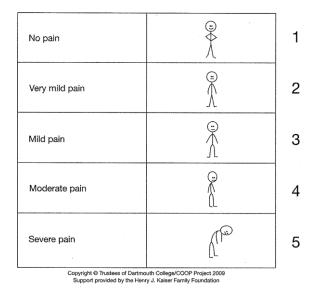
No difficulty at all		1
A little bit of difficulty	(II) ()	2
Some difficulty		3
Much difficulty		. 4
Could not do	The	5
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Staff Use: Baseline Transition

PAIN

During the past 4 weeks... How much bodily pain have you generally had?



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Please provide your most recent results and date:

	Healthy range	Results and Date:
Blood Pressure	Less than 120/80	
Total Cholesterol	Less than 200	
HDL Cholesterol	More than 40	
LDL Cholesterol	Less than 100	
Triglycerides	Less than 150	
Hemoglobin A1C	Less than 6%	
Fasting Glucose	Less than 100	
		Only the DATE is needed for each category below.
Preventive Exam	Every year	
Eye Exam	Every 1-2 years	
Dental Exam	Every 6 months	

Dental Exam	Every 6 months	
Flu Shot	Every year	
Tetanus Shot	Every 10 years	
Zostavax (Shingles) Shot	Once*	
Colonoscopy	Every 10 years*	
Prostate Cancer Screening	Every Year**	
Cervical Cancer Screening	Every 1-3 years	
Mammogram	Every 1-2 years*	
Osteoporosis screening	Age 65**	

*Based on age and/or previous results **Based on age, risk factors, symptoms and discussion with Primary Care Provider.



Lifestyle Tracker

Social Support/Well being			
# days per week I have a positive social interaction			
# days per week I feel a sense of purpose and/or joy in my life			
Stress Resiliency			
EVIDENCE-BASED TOOLS # 20-minute sessions per week (meditation, breath awareness, etc.)			
SLEEP # nights per week I am getting 7-9 hours of sleep			
Nutrition			
FRUITS # days per week I consumed 1½+ cups of fruit			
VEGETABLES # days per week I consumed 2+ cups of vegetables			
UNSWEETENED BEVERAGES # days per week I only drink unsweetened beverages			
Exercise			
# aerobic exercise sessions per week			
Average intensity of aerobic sessions (please circle)	Light (no major change in breathing pattern)	Moderate (start to sweat, able to talk but not sing)	Intense (rapid breathing, able to speak only a few words between breaths)
# Average minutes per session of aerobic exercise			
# of total body (all major muscle group) strengthening sessions per week			
# of total body stretching sessions per week			

