Thomas Cigno, M.D.

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Wellness Assessment Form

The information collected on this Wellness Assessment Form will help inform your Health Coach about your current health status and help them get to know you. Collecting this data will assist in the assessment of your overall wellness and in creating an exercise and nutrition plan to address your specific needs. Please complete the entire form.

All information contained on this form will be kept strictly confidential. The services and suggestions of the Health Coach are at all times meant to help with your general feeling of wellness and are in no way meant to diagnose or treat any disease.

Member Name: _____ Sex: _____ DOB: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: _____

Occupation: _____ Travel Required?: _____

Please circle the technologies you have access to: Computer Internet Email Skype Social Media

In order of importance to you, what are your main concerns in regards to physical activity, eating right, sleeping well, and being at a healthy weight?

1. _____
2. _____
3. _____
4. _____

Do you have family to support you on your journey towards optimal health and wellness? _____

_____

Dietary Habits:

How many meals do you have per day and when?: _____

_____

How many snacks do you have per day and when?: _____

_____

Do you usually eat meals:

_____With family _____Home alone _____With friends _____In front of TV

_____At a restaurant _____Fast food _____On the run _____While doing other activities

How many glasses of water do you drink per day? _____

Do you consume beverages with your meals? _____No _____Yes If so, what do you drink? _____

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Do you feel that there are restrictions on your diet? _____No _____Yes If so, what are they? _____

_____

Describe your diet (circle one): Meat Eater Vegetarian Vegan Other: _____

What foods do you crave, if any?: _____

Do you avoid certain foods? _____No _____Yes If so, what are they and why do you avoid them? _____

_____

Do you experience any symptoms after meals? _____No _____Yes If so, please explain: _____

_____

Please complete a seven-day food journal and bring it to your appointment. List what you eat for breakfast, lunch, dinner and snacks each day, noting meal times and portions whenever possible.

Lifestyle:

How many hours of sleep do you get per night? _____

How do you feel when you awaken? _____

How often do you exercise? _____

What type of exercise do you do and for how long? _____

_____

Do you have access to exercise equipment? _____

Do you vacation regularly? _____ When was your last vacation? _____

Do you enjoy your work? _____ What are your typical work hours? _____

Do you smoke? _____ If so, how much? _____

Are you around second-hand smoke? _____ Do you use recreational drugs? _____

What are your interests and hobbies? _____

_____

Do you have any pets? _____

Please list how many hours you spend in a typical day doing the following:

Driving _____ Watching TV _____ Reading _____ Using a computer _____

Hobbies/Relaxing _____

Is there anything else you would like to share with me? _____

Thank you for taking the time to complete this wellness assessment.

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Name:_____ Date of Birth:_____

Please be honest with each of the following questions.

Place a check in the box the best describes your **current** state.

Physical Activity

☐ I am not active and I do not plan to start.	Pre-Contemplation
☐ I am not active but I am thinking about starting.	Contemplation
☐ I am getting ready to become active.	Preparation
☐ I do some activity but need to do more.	Action
☐ I have been active regularly for several months.	Maintenance

Eating Well (Nutrition)

☐ I do not eat well and do not plan to change.	Pre-Contemplation
☐ I do not eat well but I am thinking about changing.	Contemplation
☐ I am planning to change my diet.	Preparation
☐ I sometimes eat well but need to do more.	Action
☐ I have eaten well regularly for several months.	Maintenance

Managing Stress

☐ I do not manage stress well and plan no changes.	Pre-Contemplation
☐ I am thinking about making changes to manage stress.	Contemplation
☐ I am planning to change to manage stress better.	Preparation
☐ I sometimes take steps to manage stress better but need to do more.	Action
☐ I have used good stress-management techniques for several months.	Maintenance

Weight Management

☐ I do not manage my weight well and plan no changes.	Pre-Contemplation
☐ I am thinking about making changes to weight management.	Contemplation
☐ I am planning to change to manage my weight better.	Preparation
☐ I sometimes take steps to manage my weight but need to do more.	Action
☐ I have used good weight-management techniques for several months.	Maintenance

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How Healthy Is Your Diet?

Circle your answers after careful thought, then add up your points (numbers in parentheses).

1. **How many fruits do you *normally* eat each day (1/2 cup fresh or 1/4 cup dried fruit, 1 medium piece fresh, 1 cup *unsweetened* juice)?**
   A. 0 (-2)
   B. 1 (0)
   C. 2 to 3 (+2)
   D. 4 or more (+3) (score) _____

2. **How many vegetable servings do you *normally* eat each day (1 cup leafy greens, 1/2 cup any other veggie, raw or cooked)?**
   A. 0 (-4)
   B. 1 (0)
   C. 2 (+1)
   D. 3 (+2)
   E. 4 or more (+3) (score) _____

3. **How many different varieties of vegetables do you eat in a normal month?**
   A. 2 or less (-4)
   B. 3 to 4 (0)
   C. 5 to 6 (+1)
   D. 7 to 8 (+3)
   E. 9 or more (+4) (score) _____

4. **How many times do you eat beans or peas (legumes, lentils, chickpeas, kidney beans, green peas, etc.) in a normal week?**
   A. 0 (-2)
   B. 1 to 2 (0)
   C. 3 to 4 (+1)
   D. 5 to 6 (+2)
   E. 7 or more (+3) (score) _____

5. **How many times do you eat red meat in a normal week?**
   A. 6 or more (-4)
   B. 4 to 5 (-3)
   C. 1 to 3 (-1)
   D. Less than once a week (+2)
   E. 0 (+3) (score) _____

6. **How many times do you eat in a fast food restaurant in a normal week?**
   A. 6 or more (-5)
   B. 4 to 5 (-4)
   C. 1 to 3 (-3)
   D. Less than once a week (-2)
   E. 0 (0) (score) _____

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7. In a typical day, what do you drink *most* often?
A. Soda (regular or diet) (-4)
B. Caffeinated coffee or tea (-1)
C. Decaffeinated coffee or tea (0)
D. Milk or fruit juice (0)
E. Herbal tea or water (+3) (score) _____

8. How many 12 oz. cans of soda do you drink in a normal day?
A. 6 or more (-5)
B. 4 to 5 (-4)
C. 2 to 3 (-3)
D. 1 (-2)
E. Less than 1 (-1)
F. 0 (0) (score) _____

9. How often do you eat fish in a typical week?
A. Never (-2)
B. Once (+1)
C. Twice (+2)
D. 3 to 5 times (+3) (score) _____

10. In a typical week, how often do you eat whole grains (100% whole grain bread, whole oats, brown rice, quinoa, whole rye crackers)?
A. Never (-3)
B. 1 to 2 times a week (-1)
C. 3 to 4 times a week (0)
D. 5 to 6 times a week (+1)
E. 1 or more times a day (+3) (score) _____

11. How often do you eat sweets such as cookies, cakes, or ice cream?
A. 1 or more times a day (-3)
B. Every other day (-2)
C. Twice a week (-1)
D. Once a week (0)
E. 2 to 3 times a month (+1)
F. Rarely (+3) (score) _____

Your Total Score_____

Scoring:
22–28 – Great eating habits
17–21 – Pretty good eating habits
10–16 – Needs some improvement
9 or less – Needs much improvement; try to change one habit at a time

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The Healthy Lifestyle Questionnaire

Name:_____ Date:_____

Place a 1 in the box to answer YES. If you answer "NO", make no entry.

Physical Activity

- ☐ I accumulate 30 minutes of moderate physical activity most days of the week. (Brisk walk, stair climbing, yard work, home chores…)
- ☐ I do vigorous activity that elevates my heart rate for 20 minutes at least 3 times per week.
- ☐ I do exercise for flexibility at least 3 days per week.
- ☐ I do exercises for muscle at least 2 days per week.
- ☐

Nutrition

- ☐ I eat three regular meals each day.
- ☐ I select appropriate serving sizes of a variety of nutritious foods.
- ☐ I restrict the amount of fat in my diet.
- ☐ I consume only as many calories as I expend each day.
- ☐

Stress Management

- ☐ I am able to identify situations in daily life that cause stress.
- ☐ I take time out during the day to relax and recover from daily stress.
- ☐ I find time for family, friends, and things I especially enjoy doing.
- ☐ I regularly perform exercises designed to relieve tension.
- ☐

In each category:
Scoring 3 or more is indicative of generally positive lifestyles.

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Therapeutic Readiness to Change Assessment Form

Name: _____ Date: _____

This questionnaire is to help you and your medical provider or therapist understand how ready you are to change and your chances of being successful. By filling this out, your ability to change for the positive will be greatly increased.

1. Do you see any correlation with your current lifestyle and habits affecting your current symptoms and illness? (Circle one)

YES NO

2. Have you ever considered changing your lifestyle or habits to improve your symptoms and health? (Circle one)

YES NO

3. How do you feel about the first two questions? Please underline the answer that best fits your current situation:

Unaware & unconcerned Aware & unconcerned Aware, concerned & seeing the good and inability to change simultaneously Determined to change I am hopeful I am cautious I am humble & confident, wisdom gained from the practice of good lifestyle habits already

4. Do you feel that you have the confidence to change? (Circle one) YES NO

5. Can you imagine and list the benefits versus the losses (pros/cons) you may have if you do change? Please make a short list if you can.

_____

_____

_____

6. If you find there are barriers to you changing, can you imagine solutions to those barriers? Please briefly list what they are and how you would overcome those.

_____

_____

_____

7. If you were to change, what would be your first steps? Please briefly list your ideas. You can also ask for ideas from your provider if you're not sure what to do.

_____

_____

_____