Pinnacle Training Systems
THE SCIENTIFIC APPROACH TO YOUR SUCCESS

Fresno Unified School District
Personal Wellness Assessment

Name: _____

Gender: ☐ Male ☐ Female

Age: _____

This questionnaire requests information about your family's medical history, which is considered "genetic information" protected by the Genetic Information Nondiscrimination Act ("GINA"). You are not required to answer this question, and your answer to (or choice not to answer) this question will not affect your ability to receive an incentive (if offered) for participation. Your answer to this question will only be used for the purposes of aggregate reporting and any such aggregate report will not contain any individually identifiable information.

Family history of heart disease ☐ Yes ☐ No _____

Physical Activity

In the average week, how many times do you engage in vigorous physical activity and is done for at least 20 minutes? (Examples include running, very brisk walking, heavy labor, etc.)

☐Less than 1 time/week ☐1-2 times/week ☐More than 3 times/week

How many days per week do you get 30 minutes or more (of at least 10 minutes) of light to moderate physical activity? Examples include walking, mowing, slow-cycling.

☐7 days ☐5-6 days ☐3-4 days ☐1-2 days ☐None

Dietary Habits

Each day, how many servings of food do you eat that are high in fat or cholesterol, such as fatty meat, cheese or fried foods?

☐Rarely/Never ☐1-2 servings ☐3-4 servings ☐More than 5 servings

On average, how many servings of fruits/vegetables do you eat/day?

☐More than 5 servings ☐3-4 servings ☐1-2 servings ☐Never

On average, how many full-sugar sodas do you drink per day?

☐None ☐1-2 servings ☐ 3-4 servings ☐More than 4

How many days per week do you eat breakfast?

☐7 days ☐5-6 days ☐3-4 days ☐<3 days

Lifestyle Habits

How would you describe your smoking habits?

☐Still smoke ☐Used to smoke ☐Never smoked

If you still smoke, how many cigarettes per day? _____

Do you chew tobacco ☐Yes ☐No _____

How many drinks of alcoholic beverages do you have in a typical week?
(One drink = one beer, glass of wine, or shot of liquor)

☐0 drink/week ☐1-2 drinks/week ☐ >2 drinks/week

In general, how strong are your social ties with family and/or friends?

☐Very strong ☐ About average ☐Weaker than average ☐Not sure

How often do you feel tense, anxious or depressed?

☐ Often ☐ Sometimes ☐ Rarely ☐ Never

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

☐ A lot ☐Some ☐Hardly any ☐ None

On average, how many hours of TV do you watch per day?

☐0 ☐1-2 hours/day ☐3-4 hours/day ☐ >4 hours/day

On average, how many hours of sleep do you get per night?

☐More than 7 hours/night ☐5-6 hours/night ☐ Less than 5 hours/night

How many times in the last month did you drive or ride in a car when the driver had too much to drink?

☐1 ☐More than 1

What percentage of time do you use your seatbelt?

☐100% ☐ 90-99% ☐ 80-89% ☐ less than 80%

On average, how close to the speed limit do you usually drive?

☐Within 5 miles per hour ☐6-10 mph over the limit ☐ more than 10 mph

When in the sun, do you protect your skin by using a sunscreen at SPF 15 or above and wearing appropriate clothing?

☐All the time ☐ Most of the time ☐Some of the time ☐Rarely or never

Considering your age, how would you describe your overall health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

In general, how satisfied are you with your life (include professional and personal aspects)?

☐Completely satisfied ☐Mostly satisfied ☐Partly satisfied ☐Not satisfied

Current Health

Have you had a flu shot within the last 6 months? ☐Yes ☐No

Over the past 2 weeks, how often have you had little or no pleasure in doing things?

☐Not at all ☐Several days ☐More than half the days ☐Nearly everyday

Over the past 2 weeks, how often have you been feeling down, depressed or hopeless?

☐Not at all ☐Several days ☐More than half the days ☐Nearly everyday

Please indicate which ONE of the following statements best describes your CURRENT level of physical activity?

☐I currently do not exercise, and I do not intend to start exercising for the next 6 months.
☐I currently do not exercise, but I am thinking about starting in the next 6 months.
☐I currently exercise some, but not regularly.
☐I currently exercise regularly, but I have only begun to do so within the last 6 months.
☐I currently exercise regularly, and have done so for longer than 6 months.

Please indicate which ONE of the following 8 statements best describes your CURRENT level of physical activity or your readiness to do physical activity.

☐ I do not do regular vigorous or moderate exercise now, and I do not intend to start in the next 6 months.
☐ I do not do regular exercise now, but I am thinking about starting in the next 6 months.
☐ I am trying to start doing vigorous or moderate exercise, but I do not do it regularly.
☐ I am doing vigorous exercise less than 3 times per week (or) moderate exercise less than 5 times a week.
☐ I have been doing 30 minutes of moderate exercise 5 or more days a week for the last 1-5 months.
☐ I have been doing 30 minutes of moderate exercise 5 or more days a week for 6 months or more.
☐ I have been doing vigorous exercise 3 or more days a week for the last 1-5 months.
☐ I have been doing vigorous exercise 3 or more days a week for the 6 months or more.

For the following list of conditions, please circle what you CURRENTLY have or are under care for:

Allergies
Arthritis
Asthma
Back Pain
Cancer
Chronic Bronchitis
Depression
Diabetes
Heart Problems
Heartburn
Migraines
Sleep disorders
Osteoporosis

Other conditions:_____

In the next six months, are you planning to make any changes to keep yourself healthy or improve your health?

Increase physical activity:	☐ Yes	☐ No	☐ Don't know	☐ N/A
Lose weight:	☐ Yes	☐ No	☐ Don't know	☐ N/A
Reduce alcohol use:	☐ Yes	☐ No	☐ Don't know	☐ N/A
Quit smoking:	☐ Yes	☐ No	☐ Don't know	☐ N/A
Reduce fat intake:	☐ Yes	☐ No	☐ Don't know	☐ N/A
Lower blood pressure:	☐ Yes	☐ No	☐ Don't know	☐ N/A
Lower cholesterol levels:	☐ Yes	☐ No	☐ Don't know	☐ N/A
Cope better with stress:	☐ Yes	☐ No	☐ Don't know	☐ N/A

Do you have a primary care provider? ☐ Yes ☐ No

When did you last visit your primary care provider?

Within the last year☐ 1-2 years ago☐ 2-3 years ago☐ > 3 years ago☐

When was your last vision exam?

Within the last year☐1-2 years ago☐ > 2 years ago☐

When was your last dental exam?

Within the last year☐1-2 years ago☐> 2 years ago☐

If you are a female between the ages of 50-74, when was your last mammogram?

Within the last 2 years ☐ 2-5 years ago ☐ > 5 years ago☐

☐ I have never had a mammogram

☐N/A- I am female but younger than 50 or older than 74

☐N/A- I am male

If you are female between the ages of 21 and 65, when was your last PAP Smear?

_____

Within the last 3 years☐3 years ago ☐I have never had a PAP Smear☐

☐N/A- I am female but younger than 21 or older than 65

☐N/A- I am male

If you are between the ages of 50-75, when was your last colorectal cancer screening test (i.e. FOB+, FIT Test, colonoscopy)?

Within the last 2 years☐ 2-5 years ago☐ 5-10 years ago☐

☐I have never had a colorectal cancer screening test

☐N/A- I am younger than 50 or older than 75

Would you like us to send your results to your primary care provider?

☐ Yes ☐ No

If yes, please provide and name and address of your primary care provider

Name of Doctor: _____

Address: _____

_____