



# HWT Questionnaires

## Personal Information

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Unit: \_\_\_\_\_ Date: \_\_\_\_\_

Gender:  Male  Female

Social Security Number: \_\_\_\_\_ or DOD ID \_\_\_\_\_

Rank: \_\_\_\_\_

Status: Select One

- Active Duty
- Family Member
- Civilian
- Reservist
- Retiree

## Contact Information

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## Emergency Information

Emergency Contact: \_\_\_\_\_

Contact Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

## Visit Information

Indicate which of the following services you will receive today:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Fitness Test      | <input type="checkbox"/> Unit Assessment           | <input type="checkbox"/> Blood Pressure Screening  |
| <input type="checkbox"/> Metabolic Test    | <input type="checkbox"/> In-processing             | <input type="checkbox"/> Fitness Testing Follow-up |
| <input type="checkbox"/> Biofeedback       | <input type="checkbox"/> Body Composition Analysis | <input type="checkbox"/> AWC Class                 |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Community Screening       |  |

Do you have any allergies? \_\_\_\_\_

Are you in any pain today? Yes No Please rate your pain: 1 2 3 4 5 6 7 8 9 10

Please describe your pain (i.e. location): \_\_\_\_\_

### Privacy Act Statement

This document may contain information covered under the Privacy Act, 5 USC 552(a), and/or the Health Insurance Portability and Accountability Act (PL 104-191) and its various implementing regulations and must be protected in accordance with those provisions. Healthcare information is personal and sensitive and must be treated accordingly. If this correspondence contains healthcare information, it is being provided to you after appropriate authorization from the patient or under circumstances that don't require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Redisclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality subjects you to application of appropriate sanction. If you have received this correspondence in error, please notify the sender at once and destroy any copies you have made.

---

## **Health and Wellness Goals**

Which of the following describe your health and wellness goals (check all that apply):

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Aerobic Fitness      | <input type="checkbox"/> Increase Strength    | <input type="checkbox"/> Lose Weight                |
| <input type="checkbox"/> General Fitness      | <input type="checkbox"/> Stop Smoking         | <input type="checkbox"/> Maintain Weight            |
| <input type="checkbox"/> Reduce Stress        | <input type="checkbox"/> Gain Muscle          | <input type="checkbox"/> Improve Diet and Nutrition |
| <input type="checkbox"/> Increase Flexibility | <input type="checkbox"/> Lower Blood Pressure | <input type="checkbox"/> Other: _____               |
| <input type="checkbox"/> Lose Body Fat        | <input type="checkbox"/> Improve Cholesterol  |   |

What is your primary health and wellness goal? \_\_\_\_\_

---

## **Smoking Habits**

Describe your current tobacco use habits.

- |   |  |
|---|--|
| <input type="checkbox"/> Never Smoked                   | <input type="checkbox"/> Previous Cigarette Smoker       |
| <input type="checkbox"/> Current Cigarette Smoker       | <input type="checkbox"/> Previous Pipe Smoker            |
| <input type="checkbox"/> Current Pipe Smoker            | <input type="checkbox"/> Previous Smokeless Tobacco User |
| <input type="checkbox"/> Current Smokeless Tobacco User | <input type="checkbox"/> Previous Cigar Smoker           |
| <input type="checkbox"/> Current Cigar Smoker           |  |

If current cigarette smoker, how often do you smoke?

\_\_\_ Cigarettes per:  Day  Week  Month  Year

If current smokeless tobacco user, how often do you use smokeless tobacco?

\_\_\_ times per:  Day  Week  Month  Year

---

## **Alcohol Consumption**

Do you consume alcohol?

- Yes  No

How often do you drink five (four for women) or more alcoholic drinks on one occasion?

\*One occasion = any event where drinking exceeds one drink per hour

- Daily  Weekly  Monthly  
 Once or twice per year  Never

How many alcoholic drinks do you consume during a typical day? \_\_\_\_\_

\*One drink = 12 oz of beer, 5 oz of wine, 1.5 ounces of 80 proof distilled spirits

---

## **Safety**

How often do you drive after drinking?

- More than once in the past 6 months  
 Once during the past 6 months  
 At least once in the past year  
 Not once during the past year

How often do you wear a helmet when you ride a motorcycle, all-terrain vehicle, or bicycle?

- Always  
 Most of the time  
 Sometimes  
 Rarely  
 Never  
 Does not apply to me

How often do you use a seat belt when you drive or ride as a passenger in a car?

- Always  
 Most of the time  
 Sometimes  
 Rarely  
 Never

---

**Dietary Habits**

About how many cups of fruits and vegetables do you eat per day?

- At least five    Four    Three    Two    One    Less than one

Indicate how often you eat the following:

	At most every meal	At least once a day	3-5 days a week	Less than 3 days a week	Rarely or never
High fiber foods					
Low-fat foods					
High sugar desserts					
High fat desserts					
Foods high in sodium					

Notes: \_\_\_\_\_

**Exercise Habits**

Do you currently exercise?    Yes    No

On average how many minutes per week do you engage in moderate intensity aerobic activity (working hard enough to raise your heart rate and break a sweat, i.e. brisk walking, swimming leisurely, leisurely biking)? \_\_\_\_\_

On average, how many minutes per week do you engage in vigorous intensity aerobic activity (e.g., jogging/running, swimming laps, jumping rope)? \_\_\_\_\_

On average, how many days per week do you engage in muscle strengthening activities (legs, hips, back, abdomen, chest, shoulders, and arms)? \_\_\_\_\_

**Other**

How many hours of sleep do you get per night? \_\_\_\_\_ hours

**Are you stressed?**

	Never	Almost Never	Some-times	Fairly Often	Very Often
In the last month, how often have you been upset because of something that happened unexpectedly?					
In the last month, how often have you felt that you were unable to control the important things in your life?					
In the last month, how often have you felt nervous and stressed?					
In the last month, how often have you felt confident about your ability to handle your personal problems?					
In the last month, how often have you felt that things were going your way?					
In the last month, how often have you found that you could not cope with all the things you had to do?					
In the last month, how often have you been able to control irritations in your life?					
In the last month, how often have you felt that you were on top of things?					
In the last month, how often have you been angered because of things that were outside of your control?					
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them.					

**Are You Confident That You Can Change?**

The following questions ask you to indicate how confident and competent you feel to achieve a healthier lifestyle. Please indicate your agreement with each item on the following scale.  
I feel confident and competent to:

	N/A	Almost Never True	Usually Not True	Sometimes but Infrequently True	Occasionally True	Often True	Usually True	Almost Always True
Improve my physical fitness								
Improve my diet and nutrition habits								
Improve my stress management skills								
Quit or cut back on tobacco use								
Improve my sleeping habits								
Drink alcoholic beverages in moderation								

**Are you ready to change?**

	N/A	I won't do it	I can't do it	I may do it	I will do it	I am doing it	I am still doing it
Improve my physical fitness							
Improve my diet and nutrition habits							
Improve my stress management skills							
Quit or cut back on tobacco use							
Improve my sleeping habits							
Drink alcoholic beverages in moderation							

**Are You At Risk For Heart Disease?**

**Risk Factors:**

Have you participated in at least 30 minutes of moderate physical activity on at least 3 days of the week for at least the last 3 months? ..... Yes  No

Did your father, brother or first degree male relative suffer a heart attack before age 55 yrs old? ..... Yes  No

Did your mother, sister or first degree female relative suffer a heart attack before age 65 yrs old? ..... Yes  No

Your BMI: Your height: \_\_\_\_ Feet \_\_\_\_ Inches Your Weight: \_\_\_\_ lbs

Have you been told that you have high cholesterol? ..... Yes  No

Have you been told that your "good" cholesterol is high? ..... Yes  No

Have you been told that you are pre-diabetic? ..... Yes  No

Have you been told that you have high blood pressure?..... Yes  No

**Known Disease:**

Any personal history of coronary or atherosclerotic disease?..... Yes  No

Any personal history of diabetes or other metabolic disease (thyroid, renal, liver)?  Yes  No

Any history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis? ..... Yes  No

**Suggestive Disease:**

Pain or discomfort in chest apparently due to blood flow deficiency? ..... Yes  No

Unaccustomed shortness of breath (perhaps during light exercise)?..... Yes  No

Dizziness or fainting? ..... Yes  No

Difficulty breathing while standing/ sudden breathing problems at night?..... Yes  No

Rapid throbbing or fluttering of the heart? ..... Yes  No

Severe pain in leg muscles during walking? ..... Yes  No

Ankle Edema (swelling)? ..... Yes  No

Known Heart Murmur ..... Yes  No