Health Assessment

Name_____________________________________________ Email__________________________________________

Title/Position______________________________________ Location/Center________________________________

** Individual results will remain private. Only those responsible for analyzing results will be able to see individual answers. **

Physical Activity

| Resting Heart Rate: |  |
| Blood Pressure: |  |
| BMI (Body Mass Index)*: |  |
| % Body Fat: |  |

Chart to be filled out by a health professional

BMI Calculator:

Weight in pounds: ________ * 0.4536 = Weight in kilograms: ________

Height in inches: ________ * 2.54 = Height in centimeters: ________

Height^2 in centimeters: ________

Weight in kilograms: ________ / Height^2 in cm: ________ = BMI: ________

1. On average, how many days a week do you exercise?

   0  1  2  3  4  5  6  7

2. On a scale of 1-10, how important is your physical health to you?

   1  2  3  4  5  6  7  8  9  10
   Not important  Extremely important

3. On a scale of 1-10, how would you describe your energy level during the day?

   1  2  3  4  5  6  7  8  9  10
   Low energy  High energy

This health assessment has been adapted from the CDC health assessment example and Live Well San Diego
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4. On a scale of 1-10, how would you rank your amount of movement during the work day?

1  2  3  4  5  6  7  8  9  10
Rarely move Always moving

5. Are you at your ideal weight? Yes No

6. Do you have any chronic pain or medical problems that prevent you from doing certain physical activity? (Eg. Chronic back pain, knee problems, etc.) If so, describe:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Nutrition

1. How would you describe your eating habits?
   Poor  Fair  Good  Excellent

2. On average, how many servings of fruits and vegetables do you eat each day? ______

3. On average, how many servings of fried or fatty foods do you eat each day? ______
   (e.g. Fried chicken, French fries, bacon, potato chips, donuts, cheese, etc.)

4. On average, how many sugar-sweetened drinks (not diet) do you drink each day? ____

5. What is your greatest obstacle (if any) to maintaining a healthy diet?
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

6. Do you have any diet restrictions or illnesses that cause you to alter your diet in some way?
   (eg. diabetes, allergies, religious restrictions, vegetarian/vegan)
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

Job Satisfaction

1. On average, how many hours of sleep do you get at night? __________

2. In the past two weeks, how often have you felt overly tired during the day at work?
   Almost all the time  Most of the time  Some of the time  Almost never

3. In the past two weeks, how often have you felt unsatisfied with your job or work environment?
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
4. Do you find it difficult to perform your daily activities because of lack of energy?

   Yes   No

5. How would you describe your energy level during the work day?

   High   Moderate   Low

6. How many days this year have you missed work for a health reason?

   ________

Mental Health/Stress Management

1. In the past two weeks, how often have you felt down or depressed?

   Almost all the time   Most of the time   Some of the time   Almost never

2. In the past two weeks, how often have you felt nervous, anxious, or on edge?

   Almost all the time   Most of the time   Some of the time   Almost never

3. How often is stress a problem for you in handling work, health, finance, family, or relationships?

   Almost all the time   Most of the time   Some of the time   Almost never

4. On a scale of 1-10, how would you rate your relationship with your coworkers?

   1   2   3   4   5   6   7   8   9   10
   Terrible   Perfect