

Personal Information

First Name: _____ Last Name: _____

Date: _____ Gender: Male
 Female

Social Security Number: _____ or DOD ID _____

Military Branch: Select One

- Army
- Air Force
- Navy
- Marine Corp
- Coast Guard

Status: Select One

- Active Duty
- Reserve
- Guard
- Civilian
- Family Member
- Retiree
- Other: _____

Unit (Specify your Unit Identification Code): _____

Rank (ex. SGT E-5): _____

Contact Information

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Information

Emergency Contact: _____

Contact Relationship: _____ Phone: _____

Primary Doctor: _____ Phone: _____

Visit Information

Do you have any allergies?

Are you in 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):

Referral Information (for first-time visitors only)

1. How did you **learn** about the Army Wellness Center?
 - Electric Media (e.g. website, social media, video, online advertisement)
 - Print Media (e.g. paper advertisement, flyer, brochure)
 - Briefing or Presentation (e.g. in-processing brief, orientation brief, presentation)
 - Health Fair
 - Word of Mouth
 - Other (specify): _____

2. If you selected **word of mouth**, specify from whom:
 - Friend
 - Family member
 - Coworker
 - Unit Commander, Leader, or Supervisor
 - Doctor/Physician
 - Nurse
 - Dietician
 - Physical Therapist
 - Behavioral Health Provider
 - Army Wellness Center Staff
 - Fitness Professional/Moral, Welfare, and Recreation (MWR)

3. How were you **referred** to the Army Wellness Center?
 - Not referred/self-referred
 - Friend
 - Family member
 - Coworker
 - Unit Commander, Leader, or Supervisor
 - Doctor/Physician
 - Nurse
 - Dietician
 - Physical Therapist
 - Behavioral Health Provider
 - Army Wellness Center Staff
 - Fitness Professional/Moral, Welfare, and Recreation (MWR)
 - Other (specify): _____

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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"/> Improve APFT Performance |
| <input type="checkbox"/> Lose Body Fat | <input type="checkbox"/> Improve Cholesterol | <input type="checkbox"/> Other: _____ |

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 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

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
-

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

- Always
 Most of the time
 Sometimes
 Rarely
 Never

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

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low-fat foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High sugar desserts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High fat desserts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foods high in sodium	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

Exercise Habits

Do you currently exercise? Yes No

1) 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)? _____

2) On average, how many **minutes per week** do you engage in vigorous intensity aerobic activity (e.g., jog-ging/running, swimming laps, jumping rope)? _____

3) 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

Army Physical Fitness Test (APFT) Performance * ONLY APPLICABLE FOR ACTIVE DUTY AND RESERVIST

Please enter the information requested below about the MOST RECENT Army Physical Fitness Test (APFT) that you COMPLETED FOR RECORD. If your most recent APFT was not completed for record or if you have never completed an APFT for record then there is no need to complete this form.

Do not enter any information below about APFTs that you completed for diagnostic purposes.

Test Date: (MM/DD/YYYY; Please provide your best estimate if you do not know the exact date)

Did you complete the 2-mile run event?

- Yes
 No

2-mile run time: (raw time as MM:SS, NOT POINTS)

Did you complete the push-up event?

- Yes
 No

Raw number of push-ups: (raw number, NOT POINTS)

Did you complete the sit-up event?

- Yes
 No

Raw number of sit-ups: (raw number, NOT POINTS)

Did you pass this APFT?

- Yes
 No
 Don't Know

What was the minimum number of points required to pass this APFT?

- Minimum of 150 points total (50 points per event)
- Minimum of 180 points total (60 points per event)
- Don't Know

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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt that you were unable to control the important things in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt nervous and stressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt confident about your ability to handle your personal problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt that things were going your way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you found that you could not cope with all the things you had to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you been able to control irritations in your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt that you were on top of things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you been angered because of things that were outside of your control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve my diet and nutrition habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve my stress management skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quit or cut back on tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve my sleeping habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink alcoholic beverages in moderation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve my diet and nutrition habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve my stress management skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quit or cut back on tobacco use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improve my sleeping habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink alcoholic beverages in moderation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 Don't Know

Have you been told that you have high blood pressure? Yes No Don't Know

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