

Healthy Foundations

Assessments

Important Note

To complete this assessment electronically:

1. Download and save the file to your computer.
2. Open, complete and save the form in the Adobe Acrobat Reader program.
(DO NOT complete the form in an Internet browser. Your information may not save.)
3. When done attach the PDF to an email and return to your Healthy Foundations contact.

Member Name: _____

Date: _____

The following assessments serve as a learning tool for you and the Healthy Foundations team. Please select the best response as it relates to you on a typical day. Information is only reported at an aggregate level and your responses will remain anonymous.

Staff Use: Baseline Transition

Work Questionnaire

Absenteeism

How many days within the last 3 months have you missed work due to illness or injury?

0-3 4-7 8-11 12-15 15+

How many days within the last 3 months have you missed work due to Short Term Disability or Long Term Disability?

0-3 4-7 8-11 12-15 15+

Productivity

In thinking about your productivity at work over the last 4 weeks, have you been MORE, LESS, or EQUALLY PRODUCTIVE?

More productive Less productive Equally productive

Work-life balance

In thinking about your work life balance over the last 4 weeks, have things been BETTER, WORSE, or THE SAME?

Better Worse The same

Your Name (please print): _____

Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? Select the number (0-3) corresponding with your response.	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

If you checked off any problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all: 0	Somewhat difficult: 1	Very difficult: 2	Extremely difficult: 3
Staff Use: Total of each column:				

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Your Name (please print) _____

Date _____

Perceived Stress Scale (PSS)

The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, you are being asked to indicate *how often* you felt or thought a certain way. Please read each question carefully and select your answer.

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

1. In the last month, how often have you felt that you were unable to control the important things in your life? 0 1 2 3 4

2. In the last month, how often have you felt confident about your ability to handle your personal problems? 0 1 2 3 4

3. In the last month, how often have you felt that things were going your way?..... 0 1 2 3 4

4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? 0 1 2 3 4

Staff
Use:

Score:

The PSS Scale is reprinted with permission of the American Sociological Association, from Cohen, S., Kamarck, T., and Mermelstein, R. (1983). Mind Garden, Inc.



Adherence to Medication Assessment Survey

Staff Use: Baseline Transition

Your Name (please print) _____

Date: _____

	Motivation Quadrant	Knowledge Quadrant
1) Do you ever forget to take your medicine?	Yes (0 point) _____ No (1 point) _____	
2) People sometimes miss taking their medicines for reasons other than forgetting. Are there days when you do not take your medicine?	Yes (0 point) _____ No (1 point) _____	
3) When you feel better, do you sometimes stop taking your medicine?		Yes (0 point) _____ No (1 point) _____
4) Sometimes, if you feel worse when you take your medicine, do you stop taking it?		Yes (0 point) _____ No (1 point) _____
5) Do you know the long-term benefit of taking your medicine as told to you by your doctor or pharmacist?		Yes (1 point) _____ No (0 point) _____
6) Sometimes do you forget to refill your prescription medicine on time?	Yes (0 point) _____ No (1 point) _____	
Staff Use:	Questions 1+2+6= _____	Questions 3+4+5 = _____








Name (please print):

Date:

DAILY ACTIVITIES

During the past 4 weeks...

How much difficulty have you had doing your usual activities or task, both inside and outside the house because of your physical and emotional health?






No difficulty at all		1
A little bit of difficulty		2
Some difficulty		3
Much difficulty		4
Could not do		5

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PAIN

During the past 4 weeks...

How much bodily pain have you generally had?

No pain		1
Very mild pain		2
Mild pain		3
Moderate pain		4
Severe pain		5

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Lifestyle Tracker

Social Support/Well being			
# days per week I have a positive social interaction			
# days per week I feel a sense of purpose and/or joy in my life			
Stress Resiliency			
EVIDENCE-BASED TOOLS # 20-minute sessions per week (meditation, breath awareness, etc.)			
SLEEP # nights per week I am getting 7-9 hours of sleep			
Nutrition			
FRUITS # days per week I consumed 1½+ cups of fruit			
VEGETABLES # days per week I consumed 2+ cups of vegetables			
UNSWEETENED BEVERAGES # days per week I only drink unsweetened beverages			
Exercise			
# aerobic exercise sessions per week			
Average intensity of aerobic sessions (please select)	Light (no major change in breathing pattern)	Moderate (start to sweat, able to talk but not sing)	Intense (rapid breathing, able to speak only a few words between breaths)
# Average minutes per session of aerobic exercise			
# of total body (all major muscle group) strengthening sessions per week			
# of total body stretching sessions per week			