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

Healthy Foundations Member Enrollment Form

Your name (Last, First, Middle): _____ Date: _____

Preferred name (if applicable): _____ DOB: _____

Gender: _____ Preferred Pronoun: _____

Your address: _____

City: _____ State: _____ Zip code: _____

Preferred phone: _____ ☐Home ☐Cell ☐Work

Preferred email:_____

Occupation:_____

Your ethnicity: ☐Hispanic/Latino OR ☐ Not Hispanic/Latino

Your race:

☐American Indian or Alaskan Native

☐Asian

☐Black or African American

☐Native Hawaiian/Other Pacific Islander

☐White

☐Other:_____

☐Prefer to not answer

Your preferred language:_____

Health Overview

1. What health conditions do you live with? Please check all that apply:

Diabetes Type 1 ☐ High Cholesterol ☐ High Blood Pressure ☐

Diabetes Type 2 ☐ Chronic Obstructive Pulmonary Disease ☐ Sleep Apnea ☐

Asthma ☐ Heart Disease (or other cardiac condition) ☐ Depression ☐

Anxiety ☐ Spine and/or joint pain ☐

Other:_____

2. What medications and supplements do you take (name, reasoning, dosing/frequency)?

Medication:_____ Medication:_____

Reasoning:_____ Reasoning:_____

Dosing/frequency:_____ Dosing/frequency:_____

Medication:_____ Medication:_____

Reasoning:_____ Reasoning:_____

Dosing/frequency:_____ Dosing/frequency:_____

Medication:_____ Medication:_____

Reasoning:_____ Reasoning:_____

Dosing/frequency:_____ Dosing/frequency:_____

Additional space: _____

3. What are your allergies? (including medication allergies):_____

4. Do you sometimes consume: alcoholic beverages? Yes ☐ No ☐ recreational drugs? Yes ☐ No ☐

If yes to above: Do you feel you need to cut back or quit? _____

5. Do you use tobacco products? Yes ☐ No ☐

If yes to above: Are you interested in information on quitting? Yes ☐ No ☐

6. What prior surgeries have you had, and when?

Surgery:_____ Date: _____

Surgery:_____ Date: _____

Surgery:_____ Date: _____

Additional space: _____

7. Who is your primary care provider? _____

8. What clinic is your primary care provider with? (if any) _____

Are you satisfied with the care you receive from your primary care provider? Yes ☐ No ☐

9. What other doctors or providers do you see on a regular basis?

Provider name:_____ Specialty:_____

Provider name:_____ Specialty:_____

Provider name:_____ Specialty:_____

10. What health conditions run in your family (your siblings, parents, children, or grandparents)?

Health condition:_____ Family member: _____

Health condition:_____ Family member: _____

Health condition:_____ Family member: _____

Health condition:_____ Family member: _____

Additional space: _____

11. Do you have an advanced directive? Yes ☐ No ☐

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 ☐

Staff Use: Baseline Transition

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:				

Staff Use: Baseline Transition

#1, 4, score 0-4. #2, 3, score 4-0; max of 16

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**

		Staff Use:
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** ☐ ☐ ☐ ☐ ☐	_____ Score:

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 = _____

Staff Use: Baseline Transition

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 ☐

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 ☐

Health Measurement Tracker

Name (please print): _____

Please provide your most recent results and date:

	Healthy range	Results and Date:
Blood Pressure	Less than 120/80	
Total Cholesterol	Less than 200	
HDL Cholesterol	More than 40	
LDL Cholesterol	Less than 100	
Triglycerides	Less than 150	
Hemoglobin A1C	Less than 6%	
Fasting Glucose	Less than 100	
		Only the DATE is needed for each category below.
Preventive Exam	Every year	
Eye Exam	Every 1-2 years	
Dental Exam	Every 6 months	
Flu Shot	Every year	
Tetanus Shot	Every 10 years	
Zostavax (Shingles) Shot	Once*	
Colonoscopy	Every 10 years*	
Prostate Cancer Screening	Every Year**	
Cervical Cancer Screening	Every 1-3 years	
Mammogram	Every 1-2 years*	
Osteoporosis screening	Age 65**	

*Based on age and/or previous results **Based on age, risk factors, symptoms and discussion with Primary Care Provider.

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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 circle)	☐ **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			