Readiness to Change and Well-Being Questionnaire

First Name ___________________________ Last Name ___________________________

Birthdate _____________________________ Gender: Male: Female:

Relationship (Please check): Single Married Separated Divorced Committed

Children # and Ages ________________________

Occupation_____________________________________________________________________

Email _____________________________ Phone _____________________________

Priorities for Coaching

I want to address the following areas with my coach (Check up to five areas):

**Overall**

- Improve well-being (health and happiness)
- Improve family well-being
- Improve energy
- Improve productivity

**Mental and Emotional**

- Improve work/life balance
- Improve sleep
- Manage stress better or reduce stress
- Reduce or quit smoking

**Physical**

- Increase physical activity
- Manage or prevent injury
- Lose weight

**Spiritual**

- Improve finances
- Improve personal relationships
- Manage drug or alcohol issues

- Improve job satisfaction
- Improve life satisfaction

**LIFE SATISFACTION**

<table>
<thead>
<tr>
<th>Sense of purpose</th>
<th>Joy</th>
<th>Gratitude</th>
<th>Work Satisfaction</th>
<th>Personal relationship satisfaction</th>
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<tbody>
<tr>
<td>Never</td>
<td>Rarely</td>
<td>Sometimes</td>
<td>Frequently</td>
<td>Most of the time</td>
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Dissatisfied Not Very Mostly Satisfied Very Mostly Applicable Satisfied Not applicable

Personal relationship satisfaction – Indicate level of satisfaction (check one please)

- Dissatisfied
- Not Very Satisfied
- Mostly Satisfied
- Very Satisfied
- Not Applicable

Page 1
**My Readiness to Change**

My readiness to make changes or improvements in my life satisfaction

- ☐ I am already maintaining good life satisfaction
- ☐ I recently started working on this
- ☐ I am planning on change this month
- ☐ I am planning a change to start in the next 6 months
- ☐ I have no present interest in making a change

**My Importance**

Rate the importance to me of having a high level of life satisfaction: 1 – 10 (highest level)

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- Not important at all
- About as important as other things right now
- Most important thing in my life right now

**My Confidence**

My confidence level in my ability to reach and sustain a high level of life satisfaction is:

1-10 (highest level)

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**Energy**

Best: My energy is high, I am vigorous, and I am able to perform at my best

Average: My energy is good, and I am able to accomplish what needs to get done

Low: My energy is low and it’s hard to accomplish what needs to get done

In a typical work-day what percentage of the time are you at (all three add up to 100% various levels of energy – physical and mental vigor or vitality):

Best Energy__________ Average Energy__________ Low Energy__________

When you are not working what percentage of the time are you at (all three add to 100%)

Best Energy__________ Average Energy__________ Low Energy__________
Energy Drains – Select the top three things that drain your energy

- Poor or insufficient sleep
- Too little exercise
- Unhealthy eating habits
- Stress
- Weight management issues
- Physical health issues
- Pessimism or emotional issues
- Work issues
- Family or relationship issues
- Other – Describe ____________________________

Energy Boosters – Select the top three things that boost your energy

- Healthy sleep
- Regular Exercise
- Healthy eating habits
- Stress management, relaxation, or fun activity
- Healthy mindset
- Healthy Family and personal relationships
- Healthy Work relationships
- Maintaining healthy weight
- Job Satisfaction
- Spiritual activities
- Healthy finances
- Other – Describe ____________________________

My Readiness to Change

My readiness to make changes or improvements in my energy levels:

- I am already maintaining good energy levels (6 months +)
- I recently started working on this
- I am planning on change this month
- I am planning a change to start in the next 6 months
- I have no present interest in making a change

My Importance

Rate the importance to me of being at my best energy level at least 50% of the time: 1 – 10 (highest level)

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My Confidence

My confidence level in my ability to reach and sustain my best energy levels at least 50% of the time is: 1-10 (highest level)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Weight

Body Mass Index

Height in inches without shoes: ____________________________
Current weight in pounds without shoes: ____________________________

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Weight in pounds one year ago: ____________________________
Weight in pounds two years ago: ____________________________
Weight in pounds five years ago: ____________________________
Weight in pounds ten years ago: ____________________________

Waist Measurement in inches: ____________________________

Describe any weight-management program pursued the last 10 years: ____________________________
My Readiness to Change

My readiness to make changes or improvements to reach and sustain a healthy weight:

☐ I am already maintaining a healthy weight (6 months +)
☐ I recently started working on this
☐ I am planning on change this month
☐ I am planning a change to start in the next 6 months
☐ I have no present interest in making a change

My Importance

Rate the importance to me of reaching and sustaining a healthy weight: 1 – 10 (highest level)

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My Confidence

My confidence level in my ability to reach and sustain a healthy weight: 1-10 (highest level)

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Exercise

Regular Physical Activity – Do you currently participate in regular physical activity?

Regular physical activity is defined as:

A. At least 20 minutes of vigorous activity 3 or more days a week (hard enough to make you breathe heavily or make your heart beat faster) or
B. At least 30 minutes of moderate intensity activity 5 or more days per week.

Yes ☐  No ☐

Other physical activity minutes – How many minutes in an average day are you physically active (gardening, physical labor, use stairs not elevator, walk not drive, etc.): ________________ minutes

Current limitations on physical activity (e.g. injuries, illness, medical conditions):

Previous limitations on physical activity (over the last 5 years):

Aerobic Exercise – How many days per week do you engage in aerobic exercise of at least 2 minutes of duration (fitness walking, cycling, jogging, swimming, aerobic dance, active sports)?

_________________________

Strength Exercises – How many times per week do you do strength building exercise for ten minutes or more, such as sit-ups, pushups or use strength training equipment?

_________________________
Flexibility or stretching exercises – How many times per week do you do stretching exercises for five minutes or more to improve flexibility of your back, neck, shoulders, and legs?

My Readiness to Change

My readiness to make changes or improvements to reach or sustain regular physical activity:

☐ I am already maintaining good physical activity levels consistently (6 months + )
☐ I recently started working on this
☐ I am planning on change this month
☐ I am planning a change to start in the next 6 months
☐ I have no present interest in making a change

My Importance

Rate the importance to me of regular physical activity: 1–10 (highest level)

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My Confidence

My confidence level in my ability to reach and sustain regular physical activity: 1-10 (highest level)

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| Breakfast and Snacks –

Breakfast – How often do you eat breakfast, more than just a roll and a cup of coffee?

☐ Eat Breakfast every day
☐ Eat breakfast most morning
☐ Eat breakfast two or three times per week
☐ Seldom or never eat breakfast

Snacks – How often do you eat “junk” snack foods between meals (e.g. chips, pastries, candy, ice cream, cookies)?

☐ Three or more times per day
☐ Once or twice per day
☐ Few times per week
☐ Seldom or never eat “junk” snack foods

FATS

Fat Intake – Indicate the kinds of food you usually eat

A. High fat examples: hamburgers, hot dogs, bologna, steaks, sour cream, cheese, whole milk, eggs, butter, cake, pastry, ice cream, chocolate, fried foods, and many fast foods.
B. Low fat examples: lean meats, skinless poultry, fish, skim milk, low fat dairy products, fruit desserts, vegetables, pasta, legumes (peas and beans)

☐ Nearly always eat the high fat foods
☐ Eat mostly the high fat foods, some low fat
☐ Eat both about the same
☐ Eat mostly low fat foods, some high fat
☐ Eat only low fat foods
Trans fats – are commonly listed as “partially hydrogenated vegetable oil” on food labels. These processed fats increase your risk of developing heart disease. Many snacks, baked goods, and even healthy-appearing breakfast cereals contain trans fats or partially hydrogenated vegetable oil. How often do you eat foods containing trans fats or partially hydrogenated oil?

- Many times each day
- At least once a day
- Occasionally
- Rarely, if ever
- I haven’t paid attention to trans fats of partially hydrogenated vegetable oils before

Breads, Grains, Fruits, Vegetables

Bread and Grains – Indicate the kinds of breads and grains you usually eat.

A. Refined grain examples: white bread, rolls, regular pancakes and waffles, white rice, typical breakfast cereals, typical baked goods
B. Whole grain examples: whole grain breads, brown rice, oatmeal, whole grain or high fiber cereals

- Nearly always eat refined grain products
- Eat mostly refined grain products
- Eat both about the same
- Eat primarily whole grain products
- Eat only whole grain products
- I have gluten intolerance or allergies to certain grains

Fruits and Vegetables – How many servings of fruits and vegetables do you eat daily? (A serving is: 1 cup fresh, 1/2 cup cooked, 1 medium size fruit, or 3/4 cup juice)

- One or less
- Two daily
- Three daily
- Four daily
- Five or more

Fluids

Water intake – How many eight ounce glasses of water do you drink on an average day?

- 6-8 glasses
- 3-5 glasses
- 1-2 glasses
- None

Number of drinks – How many alcoholic drinks do you usually have per weekday (one ounce liquor, 12 ounces of beer, or 4 ounces of wine)?

- 6-8 glasses
- 3-5 glasses
- 1-2 glasses
- Seldom or never

Soft drink intake – How many eight ounce glasses of non-diet soft drinks do you drink on an average day?

- 6-8 glasses
- 3-5 glasses
- 1-2 glasses
- Seldom or never

Number of drinks – How many alcoholic drinks do you usually have per weekend (one ounce liquor, 12 ounces of beer, or 4 ounces of wine)?

- 6-8 glasses
- 3-5 glasses
- 1-2 glasses
- Seldom or never

My Readiness to Change

My readiness to make changes or improvements to consume healthy food and drinks:

- I am already maintaining the consumption of healthy food and drinks consistently (6 months+)
- I recently started working on this
- I am planning on change this month
- I am planning a change to start in the next 6 months
- I have no present interest in making a change
My Importance

Rate the importance to me of consuming healthy food and drinks most of the time:

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</table>

- Not important at all
- About as important as other things right now
- Most important thing in my life right now

My Confidence

My confidence level in my ability to consume healthy food and drinks most of the time is 1-10 (highest level)

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Health

General Health

Complete the following statement.
In general my overall health is...

- Poor
- Fair
- Good
- Very good
- Excellent

What is your blood pressure:  My Numbers  Don’t Know
- Systolic (high number)
- Diastolic (low number)
- Total Cholesterol:
- HDL Cholesterol:
- LDL Cholesterol:
- Fasting Triglycerides level:
- Fasting Glucose level:

Physician Relationship- Do you have a primary care doctor who you trust and see regularly?
- No
- Somewhat
- Yes

Physical Exam-When was your last physical examination?
Within the last...

- Five or more years
- 3-4 years
- 2 years
- Year

Health Issues

Women’s health issues—Mark all that apply.

- Currently pregnant
- Had PAP smear within last 13 months
- Had mammogram within last 12 months
- Practice monthly breast self-exam

Men’s health issues—Mark all that apply.

- Had prostate exam within last 12 months
- Practice monthly testicle self-exam for lumps

Sick Days—How many days did you miss from work due to illness or injury the last 6 months?

Medications—How often do you use drugs or medicines (include prescription and non-prescription) that treat depression, affect your mood, help you relax, or help you sleep?

- Frequently
- Sometimes
- Rarely
- Never

Tobacco status—Mark the appropriate response:

- Use chewing tobacco regularly
- Currently smoke ten or more cigarettes daily
- Currently smoke less than ten cigarettes daily
- Smoke pipe or cigar only
- Quit smoking less than two years ago
- Quit smoking more than two years ago
- Have never smoked (or used tobacco)
Family Health History

Family health history- Mark any of the following health problems found in your family (parent, brother, sister).

- Colorectal cancer
- Breast cancer
- Depression
- Diabetes
- Coronary heart disease, heart attack, or coronary surgery before age 55 in men, before age 65 in women
- High Blood Pressure
- Suicide
- None

Personal Health History

Has a doctor informed you that you currently have any of the following health problems? If yes, mark either “Yes and is not under control” or Yes and taking medication or is under control”, otherwise please select N/A.

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<th>Problem</th>
<th>Yes and is not under control</th>
<th>Yes and taking medication or is under control</th>
<th>N/A</th>
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<td>Asthma or lung disorder</td>
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<td>Bowel polyps or inflammatory disease</td>
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<td>Cancer, other than non-melanoma skin cancer</td>
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<td>Chronic bronchitis or emphysema (COPD)</td>
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<td>Coronary heart disease, congestive heart failure, angina heart attack or surgery</td>
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<td>Depression (mental illness)</td>
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<td>Diabetes (high blood sugar)</td>
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<td>High blood pressure (140/90 or higher)</td>
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<td>High blood cholesterol (200 or higher)</td>
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<td>Sciatica or chronic back problem (musculoskeletal)</td>
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<td>Stroke or restricted blood flow to head or legs</td>
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<td>Arthritis</td>
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Current Symptoms

Mark any of the following symptoms you have experienced within the last four weeks.

- Chest pain or discomfort, frequent palpitations or fluttering in the heart
- Unusual shortness of breath
- Unexplained dizziness or fainting
- Temporary sensation of numbness or tingling, paralysis, vision problems, or lightheadedness
- Frequent urination, unusual thirst
- Frequent back pain
- Have trouble sleeping lately
- None

Bodily Pain

How much bodily pain have you had during the past four weeks?

- Very severe
- Severe
- Moderate
- Mild
- Very Mild
- None

Health Limitations

During the past four weeks, how much difficulty did you have doing your work or other regular activities as a result of your physical health?

- Could not do daily work
- Quite a bit
- Some
- A little bit
- None
My Readiness to Change

My readiness to make changes or improvements in managing my health:
- [ ] I am already maintaining the management of my health consistently (6 months +)
- [ ] I recently started working on this
- [ ] I am planning on change this month
- [ ] I am planning a change to start in the next 6 months
- [ ] I have no present interest in making a change

My Importance

Rate the importance to me of managing my health: 1 – 10 (highest level)

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Not Important at all

My Confidence

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1-10 (highest level)

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Most important thing in my life right now

Stress and Mental Health

Coping, Sleep, Stress and Emotional Issues

Coping – How well do you feel you are coping with your current stress load?
- [ ] Feeling unable to cope any more
- [ ] Often having trouble coping
- [ ] Have trouble coping at times
- [ ] Coping fairly well
- [ ] Coping very well

Sleep – How many hours of sleep do you get on average?
- [ ] Less than 6
- [ ] 6-7
- [ ] 7-8
- [ ] 8-9 or more

Stress – Mark any symptoms below that apply to you
- [ ] Minor problems throw me for a loop
- [ ] I find it difficult to get along with people I used to enjoy.
- [ ] Nothing seems to give me pleasure anymore
- [ ] I am unable to stop thinking about my problems
- [ ] I feel frustrated, impatient, or angry much of the time.
- [ ] I feel tense or anxious much of the time
- [ ] None of the above

Emotional Issues – During the past four weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional issues, such as feeling stressed or anxious?
- [ ] Extremely
- [ ] Quite a bit
- [ ] Moderately
- [ ] Slightly
- [ ] None at all.
Social Activity, Personal Loss and Social Support

Social Activity — During the past four weeks, to what extent has your physical health or emotional issues interfered with your normal social activities with family, friends, neighbors or groups?

☐ Extremely
☐ Quite a bit
☐ Moderately
☐ Slightly
☐ None at all

Personal Loss — Have you suffered a personal loss or misfortune in the last year? (For Example: a job loss, disability, divorce, separation, or the death of someone close to you).

☐ No
☐ Yes – one loss
☐ Yes – two or more losses

Social Support — Do you have friends/family with whom you can share problems/get help if needed?

☐ No
☐ Yes

Feelings

The next questions are about how you feel things have been with you during the past four weeks. For each question, please give the one answer that comes the closest to the way you have been feeling. How much of the time during the past four weeks …

1. None of the time
2. A little of the time
3. Some of the time
4. A good bit of the time
5. All of the time

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<td>Have you felt calm and peaceful?</td>
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<td>Did you have a lot of energy?</td>
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<td>Have you been a happy person?</td>
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<td>Did you take time to relax and have fun daily?</td>
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<td>Have you felt downhearted or blue? (If you answer 3 or higher, please complete the depression evaluation)</td>
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<td>Have you felt worthless, inadequate, or unimportant? (If you answer 3 or higher, please complete the depression evaluation)</td>
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Depression Evaluation

If you answered 3 or higher for the last two questions of the previous section “Feelings”, please complete the following:

A. None of the time  
B. Some of the time  
C. Most of the time  
D. All of the time

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<td>Been feeling low in energy, slowed down?</td>
<td>A</td>
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<td>Been blaming yourself for things?</td>
<td>A</td>
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<td>Had a poor appetite?</td>
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<td>Had difficulty falling asleep, staying asleep?</td>
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<td>Been feeling hopeless about the future?</td>
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<td>Been feeling blue?</td>
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<td>Been feeling no interest in things?</td>
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<td>Had feelings of worthlessness?</td>
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<td>Thought about or wanted to commit suicide?</td>
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<td>Had difficulty concentrating or making decisions?</td>
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My Readiness to Change

My readiness to make changes or improvements to reach or sustain optimal mental and emotional fitness is:

- [ ] I am already maintaining optimal mental and emotional fitness consistently (6 months + )
- [ ] I recently started working on this
- [ ] I am planning on change this month
- [ ] I am planning a change to start in the next 6 months
- [ ] I have no present interest in making a change

My Importance

Rate the importance to me of reaching and sustaining optimal mental and emotional fitness (managing stress and emotions well and maintaining a positive mindset): 1–10 (highest level)

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<td>Not important at all</td>
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<td>About as important as other things right now</td>
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<td>Most important thing in my life right now</td>
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My Confidence

My confidence level in my ability to reach and sustain optimal mental and emotional fitness (managing stress and emotions well and maintaining a positive mindset) is: 1-10 (highest level)

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