Complete this section of the questionnaire **EVERY 30 DAYS**.

HEALTH & WELLNESS TRACKER

HWT Questionnaire

Personal Information

First name:______________________________ Last name:______________________________ Date:_________________

DOB:_______________________ DOD ID:_______________________ Sex: ☐ Male ☐ Female Rank:_________________

Unit:_______________________

Military branch:

- ☐ Army
- ☐ Air Force
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard
- ☐ Space Force

Status:

- ☐ Active duty
- ☐ Reserve
- ☐ Guard
- ☐ Civilian
- ☐ Family member
- ☐ Retiree
- ☐ Other:__________________

Contact Information

Phone:______________________________ Email:______________________________

Referral Information

How did you hear about the AFWC?

- ☐ Medical provider
- ☐ Command referral
- ☐ Other:___________________________

Body Composition Status

Are you currently on your branch specific body composition program?

☐ Yes ☐ No

If YES, what date did you start the body composition program?

____

Tobacco

Do you use nicotine/tobacco products?

☐ Yes ☐ No

If yes, how often do you use?

☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Do you want to quit?

☐ Yes ☐ No

Alcohol

Do you consume alcohol?

☐ Yes ☐ No

If yes, how often do you drink?

☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Do you want to quit?

☐ Yes ☐ No

Exercise Habits

Are you currently exercising?

☐ Yes ☐ No

If yes, how many minutes of moderate/vigorous activity do you get per week?

☐ 0 ☐ Less than 50 ☐ 50-100 ☐ 100-150 ☐ 150+

If yes, how many days per week do you engage in strength training?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 5+

If no, have you regularly exercised in the past?

☐ Yes ☐ No

Sleep Habits

How many hours of sleep do you get per night?

☐ 0-3 ☐ 4-6 ☐ 7-9 ☐ 10+

Do you have sleep apnea?

☐ Yes ☐ No

How do you perceive your quality of sleep?

☐ Great ☐ Fair ☐ Poor

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HEALTH & WELLNESS TRACKER

HWT Questionnaire

Dietary Habits

Think about the past 30 days when responding to the questions below about your dietary intake and fueling (Note: Only a few examples of each are listed below to remind you of the types of food in each category – many more are possible):

	More than 3 times per day	2 times per day	1 time per day	3-6 times per week	1-2 times per week	Rarely or never
How often did you consume any **FRUIT**? Examples: fresh, frozen, canned, or dried or 100% fruit juices. A serving is 1 cup of fruit or ½ cup of fruit juice.	☐	☐	☐	☐	☐	☐
How often did you consume any **VEGETABLES**? Examples: fresh, frozen canned, cooked, or raw: dark green vegetables (broccoli, spinach, most greens), orange vegetables (carrots, sweet potatoes, winter squash, pumpkins), legumes (dry beans, chickpeas, tofu), starchy vegetables (corn, white potatoes, green peas), and other (tomatoes, cabbage, celery, cucumbers, lettuce, onions, peppers, green beans, cauliflower, mushrooms, summer squash, etc.).	☐	☐	☐	☐	☐	☐
How often did you consume any **WHOLE GRAINS**? Examples: Rye, whole-wheat, or heavily seeded bread; brown or wild rice; whole-wheat pasta or crackers; oatmeal; corn tacos.	☐	☐	☐	☐	☐	☐
How often did you consume any **DAIRY**? Examples: Regular or whole fat milk; low- or reduced-fat milk (2%, 1%, 0.5%, or skim), yogurt, cottage cheese, low-fat cheese, frozen low-fat yogurt, soymilk, or other calcium-fortified foods (orange juice, soy/rice milk, breakfast cereals, etc.).	☐	☐	☐	☐	☐	☐
How often did you consume any **FISH**? Examples: Tuna, salmon, or other non-fried fish.	☐	☐	☐	☐	☐	☐
How often did you consume **SUGAR-SWEETENED BEVERAGES**? Examples: Coke, Sprite, flavored soda, Mountain Dew, sweet tea, lemonade, Frappuccino.	☐	☐	☐	☐	☐	☐
How often did you consume **ENERGY DRINKS**? Examples: Monster, Red Bull, Rip-It, NOS, 5-Hour.	☐	☐	☐	☐	☐	☐

Health & Wellness Goals

Select **two** goals to prioritize. Mark one as Primary (1) and the other as Secondary (2):

1 2		1 2		1 2		
☐☐	Weight loss	☐☐	Improve aerobic fitness	☐☐	Improve nutrition habits	
☐☐	Weight gain	☐☐	Increase strength	☐☐	Improve sleep habits	
☐☐	Improve body composition	☐☐	Improve stress management	☐☐	Tobacco/nicotine cessation	☐ Other_________________

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Complete this section of the questionnaire if 'yes' was annotated on the 'Are You Stressed?' section and/or if you indicated that 'Improving Stress Management' is a primary or secondary goal.

HEALTH & WELLNESS TRACKER

HWT Questionnaire

Are You Stressed?

In the past 30 days, has perceived stress affected your ability to achieve your health and wellness goals?

☐ Yes ☐ No

***If answered YES, please complete the Perceived Stress Scale Survey below.**

Perceived Stress Scale Survey- (PSS 10)

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

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Complete this section of the questionnaire **EVERY 365 DAYS** or prior to a fitness assessment or exercise prescription.

HEALTH & WELLNESS TRACKER

HWT Questionnaire

First name:________________________________ Last name:________________________________ Date:__________________

ACSM/Pre-Participation Health Screening

Have you participated in structured physical activity for at least 30 minutes at moderate intensity on at least 3 days of the week for the last 90 days? (The CDC states if you are doing moderate intensity activity you can talk, but not sing during the activity).

☐ Yes ☐ No

Did your father, brother or first degree male relative suffer a heart attack before the age of 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

Height:__________ feet __________ inches Weight: __________ lbs.

Have you been told you have high cholesterol?........ ☐ Yes ☐ No

Have you been told your "good" cholesterol is high?........ ☐ Yes ☐ No

Have you been told you are pre-diabetic?........ ☐ Yes ☐ No ☐ Don't Know

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

Do you currently have (or have had in the last 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? (Please answer NO if you had a problem in the past, but it does not limit your current physical activity)........ ☐ Yes ☐ No ☐ Don't Know

Are you currently taking prescribed medication(s) for a chronic medical condition?........ ☐ Yes ☐ No

Known Personal Disease:

Do you have any personal history of cardiovascular, cardiac, peripheral vascular, or cerebrovascular disease?... ☐ Yes ☐ No

Do you have any personal history of metabolic disease, Type I or Type II diabetes, or renal disease?........ ☐ Yes ☐ No

Do you have any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?...... ☐ Yes ☐ No

Suggestive Personal Disease:

When you are at rest or physically active, do you experience:

Pain or discomfort in chest, neck, jaw, arms, or other areas that may result from blood flow deficiency?.......... ☐ Yes ☐ No

Shortness of breath at rest or with mild exertion?........ ☐ Yes ☐ No

Dizziness or fainting?........ ☐ Yes ☐ No

Difficulty breathing while lying down or sudden breathing problems at night?........ ☐ Yes ☐ No

Rapid throbbing or fluttering of the heart?........ ☐ Yes ☐ No

Severe cramping pain in leg muscles during walking?........ ☐ Yes ☐ No

Swelling of the ankles?........ ☐ Yes ☐ No

Known heart murmur?........ ☐ Yes ☐ No

Unusual fatigue or shortness of breath during usual activities?........ ☐ Yes ☐ No

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