ARMY WELLNESS CENTER

HWT Questionnaire

Personal Information

First Name:_____ Last Name: _____ Birthdate:_____

Date: _____ Gender: □ Male
□ Female

Social Security Number:_____ or DOD ID _____

Military Branch: Select One

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

Status: Select One

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

Unit (Specify your Unit Identification Code):

□ 128th Aviation □ 7th Tran □ 597th Surface Brigade □ 93Rd Signal Brigade □ TRADOC □ MCAHC □ DENTAC □ FUTURES □ Joint Task Force □ CIMT □ USA ELEMENT

Rank (ex. SGT E-5): _____

□ Other: _____

Contact Information

Home Phone:_____ Cell Phone: _____

Work Phone: _____ Email: _____

Emergency Information

Emergency Contact: _____ Phone: _____

Contact Relationship: _____ Phone: _____

Primary Doctor: _____

Health Information

Do you have any allergies? □Yes □No

If yes, please list: _____

Are you in any pain today? □Yes □No If Yes:

Please rate your pain: □1 □2 □3 □4 □5 □6 □7 □8 □9 □10

Please describe your pain (i.e. location):

_____

On Army Body Composition Program (ABC-P)?
If Yes, what was your start date? _____

□ No □ Yes

Have you been diagnosed in the past 2 years with any of the following medical conditions?

- □Heart Disease
- □Liver Disease
- □Pancreatic Disease
- □Kidney Disease
- □Hypoglycemia
- □Diabetes
- □Thyroid Problems
- □High Blood Pressure
- □High Cholesterol
- □Anemia
- □Breastfeeding
- □Gastric Bypass Surgery
- □Sleep Apnea

□Put on Profile (Active Military), if Yes please explain:

_____

_____

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):

□ Aerobic Fitness
□ General Fitness
□ Reduce Stress
□ Increase Flexibility
□ Lose Body Fat
□ Increase Strength
□ Stop Smoking
□ Gain Muscle
□ Lower Blood Pressure
□ Improve Cholesterol
□ Lose Weight
□ Maintain Weight
□ Improve Diet and Nutrition
□ Improve APFT Performance
□ Other: _____

What is your primary health and wellness goal? _____

Smoking Habits

Describe your current tobacco use habits.

☐ Never Smoked
☐ Current Cigarette Smoker
☐ Current Pipe Smoker
☐ Current Smokeless Tobacco User
☐ Current Cigar Smoker
☐ Current Vaper w/ Nicotine
☐ Current Vaper w/ No Nicotine
☐ Previous Cigarette Smoker
☐ Previous Pipe Smoker
☐ Previous Smokeless Tobacco User
☐ Previous Cigar Smoker
☐ Previous Vaper w/ Nicotine
☐ Previous Vaper w/ No Nicotine

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

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?	○	○	○	○	○
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?	○	○	○	○	○

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	☐	☐	☐	☐	☐
Low-fat foods	☐	☐	☐	☐	☐
High sugar desserts	☐	☐	☐	☐	☐
High fat desserts	☐	☐	☐	☐	☐
Foods high in sodium	☐	☐	☐	☐	☐

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 Combat Fitness Test (ACFT) Performance

*** ONLY APPLICABLE FOR ACTIVE DUTY AND RESERVIST**

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

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

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

Event 1: 3 Repetition Maximum Deadlift

Did you complete this event?

- ○ Yes
- ○ No

Maximum Weight Lifted:_____ (Raw Weight, NOT POINTS)

Event 2: Standing Power Throw

Did you complete this event?

- ○ Yes
- ○ No

Distance Thrown:_____ (Distance Thrown in Meters '0.0', NOT POINTS)

Event 3: Hand Release Push-Up

Did you complete this event?

- ○ Yes
- ○ No

Number of Push-Ups: _____ (Number of Push-Ups, NOT POINTS)

Event 4: Sprint-Drag-Carry (SDC)

Did you complete this event?

- ○ Yes
- ○ No

Event Time: _____ (Time in MM:SS, NOT POINTS)

Event 5: Plank (PLK)

Did you complete this event?

- ○ Yes
- ○ No

Event Time: _____ (Time in MM:SS, NOT POINTS)

Event 6: Select One

- ○ 2 Mile Run
- ○ 2.5 Mile Walk
- ○ 5K Row
- ○ 12K Stationary Bike
- ○ 1K Swim

Event Time: _____ (Time in MM:SS, NOT POINTS)

Did you pass ACFT?

- ○ Yes
- ○ No
- ○ Don't Know

What was the total number of points scored in this ACFT? _____ Don't Know

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	Some-times but Infre-quently True	Occa-sionally True	Often True	Usually True	Almost Always True
Improve my physical fitness	○	○	○	○	○	○	○	○
Improve my diet and nutrition habits	○	○	○	○	○	○	○	○
Improve my stress management skills	○	○	○	○	○	○	○	○
Quit or cut back on tobacco use	○	○	○	○	○	○	○	○
Improve my sleeping habits	○	○	○	○	○	○	○	○
Drink alcoholic beverages in modera-tion	○	○	○	○	○	○	○	○

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	○	○	○	○	○	○	○
Improve my diet and nutrition habits	○	○	○	○	○	○	○
Improve my stress management skills	○	○	○	○	○	○	○
Quit or cut back on tobacco use	○	○	○	○	○	○	○
Improve my sleeping habits	○	○	○	○	○	○	○
Drink alcoholic beverages in modera-tion	○	○	○	○	○	○	○

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