

WELLNESS PROGRAM

What is a Wellness Program? Simply put, it is a program designed to help employees stay well. It is the employer providing the tools and resources to allow their employees to lead a healthier life.

NEEDS & INTEREST SURVEY:

Dear Fellow Employees,

The Purpose of this Survey is to obtain everyone's input for our new health promotion program. The Survey includes questions on your needs, interests, and other pertinent information to be used in deciding what programs to offer and when to offer them.

- There is neither a right or wrong answer on this Survey.
- Feel free to skip any sections in which you feel uncomfortable supplying answers.
- Your completion of this Survey is completely voluntary.
- The Surveys are completely anonymous.
- Thank you for your participation and support.

A.) **DEMOGRAPHIC INFORMATION**

- 1) What is your age? _____ 2) What is your sex? Male Female
- 3) Are you Married? yes no 4) Do you have children living at home? yes no

B.) **TOBACCO USE**

- 1) Do you chew tobacco or rub snuff?
1 yes 2 no, but former user 3 no, never used
- 2) Do you smoke?
1 yes 2 no, but former user 3 no, never used
- 3) How would you classify your tobacco usage?
1 a current smoker (_____ amount per day)
2 never smoked
3 ex-smoker, quit _____ years ago

C.) **ALLERGIES**

- 1) Do you have allergies? 1 yes 2 no
- 2) If yes, what kind of allergies? 1 Seasonal 2 Food 3 Other
- 3) Choose your current method of treatment: over-the-counter medicine or prescription medicine
- 4) Would you like to learn more about allergies? 1 yes 2 no

D.) **NUTRITION**

Please rate how often you do each of the following:

- | | <i>Never</i> | <i>Seldom</i> | <i>Sometimes</i> | <i>Often</i> | <i>Very Often</i> |
|---|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 1) Eat fresh fruits, vegetables, whole grain breads | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| 2) Eat foods high in cholesterol or fat, such as cheeseburgers, pizzas, cheese... | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

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NEEDS & INTEREST SURVEY (continued):

	<i>Never</i>	<i>Seldom</i>	<i>Sometimes</i>	<i>Often</i>	<i>Very Often</i>
3) Eat pre-packaged / pre-prepared foods at home	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4) Eat fast foods, such as, cheeseburgers, fries, pizzas, hot dogs...	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

E.) **PHYSICAL ACTIVITY**

Please check below the category that best describes your physical activity level (Other Than Work) for the previous year:

NOTE : Moderate to vigorous activity implies the following ... any aerobic activity which raises your heart rate to a level of 70% to 80% of your target heart rate → 220 – your age = Target Heart Rate.

- 1 No Physical Activity.
- 2 Moderate to vigorous exercise 1 time per week for at least 20 minutes.
- 3 Moderate to vigorous exercise 2 times per week for at least 20 minutes, each time.
- 4 Moderate to vigorous exercise 3 times per week for at least 20 minutes, each time.
- 5 Moderate to vigorous exercise 5 times per week for at least 20 minutes, each time.

F.) **HEALTH SCREENINGS**

Please indicate whether you have had the following screenings or examinations in the Past 12 Months:

	<i>Yes</i>	<i>No</i>
1) Blood Pressure Check	1 <input type="checkbox"/>	2 <input type="checkbox"/>
2) Blood Sugar Check	1 <input type="checkbox"/>	2 <input type="checkbox"/>
3) Cholesterol Check	1 <input type="checkbox"/>	2 <input type="checkbox"/>
4) Multiphasic Blood Screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>
5) Cardiovascular Exam (EKG's)	1 <input type="checkbox"/>	2 <input type="checkbox"/>
6) Colon / Rectal Exam	1 <input type="checkbox"/>	2 <input type="checkbox"/>
7) Prostate Exam.....	1 <input type="checkbox"/>	2 <input type="checkbox"/>
8) Stool Check (Bowels)	1 <input type="checkbox"/>	2 <input type="checkbox"/>

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NEEDS & INTEREST SURVEY (continued):

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F.) HEALTH SCREENINGS cont.

Please indicate whether you have had the following screenings or examinations in the Past 12 Months:

	<i>Yes</i>	<i>No</i>
9) Mammogram	1 <input type="checkbox"/>	2 <input type="checkbox"/>
10) Vision	1 <input type="checkbox"/>	2 <input type="checkbox"/>
11) Other – Please Specify _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>

G.) PROGRAM INTERESTS

Please indicate how likely you would be to participate in each of the following programs if they were offered at work during the next year.

	<i>Extremely Likely</i>	<i>Somewhat Likely</i>	<i>Somewhat Unlikely</i>	<i>Extremely Unlikely</i>
1. <u>Body Fat Testing</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2. <u>Educational Programs:</u>				
1) Back Safety	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2) Cancer Prevention	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3) Heart Disease Prevention	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4) Stroke Prevention Programs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5) Cholesterol Reduction	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6) Home Safety	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7) Substance Abuse	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8) Headache Prevention & Treatment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9) Cold / Flu Prevention & Treatment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3. <u>Employee Assistance Programs:</u>				
1) Depression Treatment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2) Financial Management	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3) Job Stress Management	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4) Accepting Change	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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NEEDS & INTEREST SURVEY (continued):

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G.) **PROGRAM INTERESTS cont.**

Please indicate how likely you would be to participate in each of the following programs if they were offered at work during the next year.

	<i>Extremely Likely</i>	<i>Somewhat Likely</i>	<i>Somewhat Unlikely</i>	<i>Extremely Unlikely</i>
5) Parenting Difficulties	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6) Managing Chronic Health Conditions (diabetes, hypertension, ...)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7) Managing Chronic Pain (neck & shoulder injuries, back injuries, ...)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8) Controlling anger / emotions	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4. <u>Fitness Programs:</u>				
1) Corporate Fitness Membership Rates	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2) Exercise Tolerance (STRESS) Testing	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3) On-Site, Low-impact Exercise Equipment	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4) Prescribed Exercise Programs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5) Stretching Programs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6) Walk-Fit Programs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5. <u>Immunization Programs:</u>				
1) Flu Shots	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2) Tetanus Shots	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3) Lyme Disease vaccine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4) Hepatitis 'B' vaccine	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6. <u>Nutrition Education Programs:</u>				
1) Healthy Cooking (meals/snacks)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2) Cooking Venison	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3) Healthy Eating (do's & don'ts)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4) Weight Management Programs (diet & exercise)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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NEEDS & INTEREST SURVEY (continued):

G.) **PROGRAM INTERESTS cont.**

Please indicate how likely you would be to participate in each of the following programs if they were offered at work during the next year.

	<i>Extremely Likely</i>	<i>Somewhat Likely</i>	<i>Somewhat Unlikely</i>	<i>Extremely Unlikely</i>
5) Onsite Vending Machines with Healthy Choices	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7. <u>Screening Programs:</u>				
1) Blood Pressure Checks	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
2) Blood Sugar (diabetes)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
3) Cholesterol Levels	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
4) Multiphasic Blood Screenings	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
5) Cardiovascular (EKG's)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
6) Colon / Rectal (cancer)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
7) Prostate Checks (PSA)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8) Stool Checks (bowels)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9) Mammograms	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
10) Vision	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
11) Other...Specify _____	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
8. <u>Smoking Cessation Programs</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
9. <u>Stress Reduction Programs</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
10. <u>Time Management Programs</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
11. <u>Visiting onsite Healthcare Nurse</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
12. <u>Self-Help / Self-Care</u> (Learn medical treatments that you can carry out at home / home remedies).	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

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NEEDS & INTEREST SURVEY (continued):

• Please indicate how likely you would be to participate in a health promotion programs during the following times:

	<i>Extremely Likely</i>	<i>Somewhat Likely</i>	<i>Somewhat Unlikely</i>	<i>Extremely Unlikely</i>
10. Before Work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
11. During Lunch at Work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
12. After Work	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

H.) ANY OTHER INTEREST OR SUGGESTIONS (PLEASE SPECIFY)

Please list any positive (or negative) comments regarding the impact of the current Wellness Program.

Include how this program may have affected you personally.

List any suggestions on how we can improve the current program or things you would like to see implemented.

Your input is an IMPORTANT element to the success of our program.
