

attentive to YOU™

personal health survey



ATTENTIVE
HEALTH

INSTRUCTIONS

It is our pleasure to be *attentive to YOU* and to offer our professional services to help safeguard your most valuable asset: your health. Please take the next 15 minutes to honestly and thoughtfully answer the questions that follow about your health, your medical history, and your health habits. Your responses to this survey will help us provide a healthier and more supportive work environment for you and your fellow employees. By learning more about your needs & interests, we can better support you, your coworkers, and your family members. If you have any questions or concerns, please ask.

ABOUT THIS SURVEY

Attentive Health, LLC and your employer are conducting this health survey in order to attend to your personal wellbeing (both on and off the job) and support you and your family in a meaningful and personalized way. After reviewing your responses to the questions below, we will prepare a personal report for you and meet with you in person to discuss your results and answer any questions you have. Based on your particular health concerns and personal readiness, an Attentive Health coach can also help identify a few personalized action steps you can take to improve your health in the near future. If you do not wish to meet with a health coach, your report can be made available for confidential pickup.

Please note that the health information provided to you as a result of this survey is not medical advice, nor a diagnosis, and is for your own personal use. Your participation is completely voluntary, and you should contact your personal health care provider for medical advice prior to engaging in any health-related program.

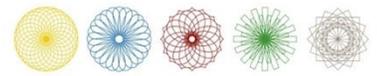
PRIVACY STATEMENT

The information collected and the results of your survey contain confidential medical information about you. Please rest assured that we understand the sensitive nature of this information and are concerned about maintaining your privacy. Attentive Health's programs comply with all applicable privacy and security laws, including HIPAA. We even go beyond what is required to ensure that your information is kept confidential. We protect your information in the following ways:

- Your individual answers and results are never shared with your employer, even anonymously. Once per year, we will combine the information collected from all participating employees at your company and create a confidential overall group health report for your employer. For example, this report might contain the number of employees who currently use tobacco, but it will not contain any information that would identify who uses tobacco. We provide these reports so that we, along with your employer, can develop future programs that can help employees and their families maintain and improve their health.
- We may notify your employer about whether you submitted a survey or participated in a health screening or other activities. No information about any answers or results is provided, only the fact of whether you participated. This information allows your employer to provide you with the appropriate incentive, if any, for your participation and to assess how the program is reaching employees.
- Our records separate information about who has completed the survey and biometric screenings from individual answers and results. Any information that we maintain in our records about your answers and results is coded and not identified to any individual. The codes are kept separately from the answers and results. The codes are retained to re-identify information when needed for a specific purpose under Attentive Health programs, in particular, to allow a disease management nurse to contact you about a health risk. This identifiable information is not provided to your employer.
- All of the information that we receive is stored using sophisticated technology for security and confidentiality.

By completing this survey, you acknowledge receiving and accepting our policies above.

MY PERSONAL PROFILE 2019



Last Name		First Name	
Company Name	Miller's Textile Services	Location	<input type="checkbox"/> Wapokoneta <input type="checkbox"/> Depot Location
Cell Phone #		Email Address	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Current Age	<input type="text"/> <input type="text"/> years old
Height (without shoes)	<input type="text"/> feet <input type="text"/> <input type="text"/> inches	Weight* (without shoes)	<input type="text"/> <input type="text"/> <input type="text"/> pounds
What was your blood pressure when it was last checked?*	<input type="checkbox"/> Normal <input type="checkbox"/> Borderline <input type="checkbox"/> High <input type="checkbox"/> Unknown		
How was your cholesterol when it was last checked?*	<input type="checkbox"/> Normal <input type="checkbox"/> Borderline <input type="checkbox"/> High <input type="checkbox"/> Unknown		
What was your blood sugar level when it was last checked?*	<input type="checkbox"/> Normal <input type="checkbox"/> Borderline <input type="checkbox"/> High <input type="checkbox"/> Unknown		

MY HEALTH CONCERNS

In general, on a scale from 1 to 10 (10 = "Excellent"), how would you rate your overall health?										
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	
How many kinds of drugs did you take in the past week? * (including prescription and over-the-counter medications, but NOT including vitamins)							<input type="text"/>	<input type="text"/>	kinds of drugs	
How many times over the past year have you:							0	1-2	3-5	6+
Visited a health care provider? (not including prenatal visits)*										
Gone to the emergency room?*										
Stayed overnight in the hospital? (not including childbirth)*										
Compared to one year ago, how would you rate your health now?							<input type="checkbox"/> Much better	<input type="checkbox"/> Somewhat better		
							<input type="checkbox"/> Same	<input type="checkbox"/> Worse		

Please mark any health conditions you currently have:*

<input type="checkbox"/> Allergies or Asthma	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression
<input type="checkbox"/> Cancer (of any kind)	<input type="checkbox"/> Heartburn or acid reflux
<input type="checkbox"/> Chronic back or neck pain	<input type="checkbox"/> Constipation/Diarrhea or IBS
<input type="checkbox"/> Chronic bronchitis/emphysema	<input type="checkbox"/> Other digestion-related problems
<input type="checkbox"/> Chronic lung disease (COPD)	<input type="checkbox"/> Intimacy-related problems
<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Migraine headaches
<input type="checkbox"/> Chronic sinus problem	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Coronary heart disease/angina	<input type="checkbox"/> Sleep-related problems
<input type="checkbox"/> Other heart problems	<input type="checkbox"/> Stroke
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Other condition:

WOMEN ONLY

At what age did you have your first menstrual cycle?*	<input type="checkbox"/> 11 or under	<input type="checkbox"/> 12-13 years old	<input type="checkbox"/> 14 or older
Do you experience painful or irregular periods?*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Have you given birth to a child weighing more than 9 lbs?*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> No children
Do you take any form of birth control medication? (pill, patch, ring, injections)*	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

* optional medical information

MY HEALTH HABITS

What types of food do you typically eat for:																			
breakfast		lunch		dinner		snacks		liquids											
How many servings of fruits do you eat daily? <i>(1 serving = a half cup of chopped, cooked or canned fruit, or one medium sized piece of fruit)</i>								<input type="text"/> servings											
How many servings of vegetables do you eat daily? <i>(1 serving = a half cup chopped, cooked or canned vegetables, or a small bowl of salad greens)</i>								<input type="text"/> servings											
How many servings of meat, pork, chicken, or fish do you eat daily? <i>(1 serving = approximately the size of a deck of cards)</i>								<input type="text"/> servings											
How many servings of milk, cheese, or ice cream do you eat daily? <i>(1 serving = 1 cup of milk, 1 slice (1 ounce) of cheese, 1/2 cup cottage cheese, 1/2 cup of ice cream)</i>								<input type="text"/> servings											
How many servings of sweets do you eat daily? <i>(1 serving = 8 oz. soft drink, 1 oz. candy, 1 small piece of cake or pie, 2 Tbsp syrup or jelly, 3-4 Tbsp sugar)</i>								<input type="text"/> servings											
How many servings per week do you usually eat whole grain cereal, oatmeal, brown rice, or whole wheat bread/rolls? <i>(1 serving = 1 slice bread, 1/2 cup oatmeal, rice, or cereal)</i>								<input type="text"/> servings											
How many times per week do you eat out <i>(restaurants, fast food, salad bars, etc.)</i>								<input type="text"/> <input type="text"/> times											
How many drinks of alcoholic beverages do you have in a typical week? <i>(1 alcoholic beverage = a 12 oz beer, a 5 oz glass of wine, a 1.5 oz shot of liquor, 1 small mixed drink)</i>								<input type="text"/> <input type="text"/> drinks											
How many cups of caffeinated beverages do you drink per day? <i>(1 cup = 8 ounces of coffee, soda, or black/green/white tea)</i>								<input type="text"/> <input type="text"/> cups											
How much water do you drink daily? <i>(a typical bottle of water contains approximately 16 ounces)</i>				<input type="checkbox"/> 0-16 oz. <i>(< 1 bottle)</i>		<input type="checkbox"/> 17-32 oz. <i>(1-2 bottles)</i>		<input type="checkbox"/> 33-64 oz. <i>(3-4 bottles)</i>		<input type="checkbox"/> 65+ oz. <i>(4+ bottles)</i>									
In general, on a scale from 1 to 10 (10 = "Excellent"), how satisfied are you with your eating habits?																			
<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4		<input type="checkbox"/> 5		<input type="checkbox"/> 6		<input type="checkbox"/> 7		<input type="checkbox"/> 8		<input type="checkbox"/> 9		<input type="checkbox"/> 10	

EXERCISE

How many days a week do you do at least 30 minutes of activity, without stopping, in which you breathe heavier and your heart beats faster?						<input type="checkbox"/> 6-7 days		<input type="checkbox"/> 3-5 days		<input type="checkbox"/> 1-2 days		<input type="checkbox"/> Rarely or never							
How many days each week do you do strength-building exercises for 15-30+ minutes? <i>(weight lifting, pushups, crunches, yoga, Pilates)</i>						<input type="checkbox"/> 3+ days		<input type="checkbox"/> 2 days		<input type="checkbox"/> 1 day		<input type="checkbox"/> 0 days							
How many days each week do you do stretching exercises? <i>(yoga, Pilates, post-workout stretching)</i>						<input type="checkbox"/> 3+ days		<input type="checkbox"/> 2 days		<input type="checkbox"/> 1 day		<input type="checkbox"/> 0 days							
How do you feel about exercising?						<input type="checkbox"/> I enjoy exercising very much		<input type="checkbox"/> I somewhat enjoy exercising		<input type="checkbox"/> I have mixed feelings about it		<input type="checkbox"/> I find exercise difficult to enjoy							
On a scale of 1-10 (10 = "Totally satisfied"), how satisfied are you with the amount of exercise you perform?																			
<input type="checkbox"/> 1		<input type="checkbox"/> 2		<input type="checkbox"/> 3		<input type="checkbox"/> 4		<input type="checkbox"/> 5		<input type="checkbox"/> 6		<input type="checkbox"/> 7		<input type="checkbox"/> 8		<input type="checkbox"/> 9		<input type="checkbox"/> 10	

SLEEP

During the past week, how many days did you get enough sleep so that you awoke feeling rested and refreshed?

- 6-7 days 4-5 days
 2-3 days 0-1 days

TOBACCO

How would you describe your smoking and/or other tobacco habits? *(including pipes & cigars)*

- Never used tobacco Used to use tobacco
 Currently smoke Currently use smokeless tobacco

wellbeing



In general, on a scale from 1 to 10 (10 = "Totally satisfied"), how satisfied are you with your life?

- 1 2 3 4 5 6 7 8 9 10

How much energy do you have on a typical day?

- High energy
 Adequate energy
 Often tired

How often do you feel tense, anxious, or irritable at work?

- Almost every day
 Sometimes
 Rarely or never

How often do you feel tense, anxious, or irritable at home?

- Almost every day
 Sometimes
 Rarely or never

How often do you use drugs or medication (including prescriptions) which affect your mood or help you to relax?*

- Almost every day
 Sometimes
 Rarely or never

Major life events are stressful, especially if they build up over a short period of time – even when they are positive. To get a sense of your personal level of significant stress factors, please check off which of the following you have experienced in the past year:

Death of a spouse	Divorce or breakup of a significant relationship
Marital separation	Imprisonment
Death of a close family member	Personal injury or illness
Marriage	Dismissal from work
Marital reconciliation	Retirement
Change in health of a family member	Pregnancy
Sexual difficulties	Gain a new family member
Business readjustment	Change in financial state
Change in frequency of arguments	Major mortgage
Foreclosure of mortgage or loan	Change in responsibilities at work
Child leaving home	Trouble with in-laws
Outstanding personal achievement	Spouse started or stopped work
Began or ended school	Change in living conditions
Revision of personal habits	Trouble with boss
Change in working hours or conditions	Change in residence
Change in schools	Change in recreation
Change in religious activities	Minor mortgage or loan
Change in sleeping habits	Change in number of family reunions

relationships



What is your current relationship status?	<input type="checkbox"/> Single/Never Married <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed									
In general, on a scale from 1 to 10 (10 = "Totally satisfied"), how satisfied are you with your:										
Relationship status (<i>i.e. being single, married, etc.</i>)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Quality of your relationships	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Social life	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Home environment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Do you have any children?	<input type="checkbox"/> Yes <input type="checkbox"/> No									
Do you have any grandchildren?	<input type="checkbox"/> Yes <input type="checkbox"/> No									
Do you have a best friend at work?	<input type="checkbox"/> Yes <input type="checkbox"/> No									
Do you have a best friend outside of work?	<input type="checkbox"/> Yes <input type="checkbox"/> No									
Over the past year, how often have you felt that you are receiving good support from friends and family?	<input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Most of the time <input type="checkbox"/> Almost Always									

career & finance



In general, on a scale from 1 to 10 (10 = "Totally satisfied"), how satisfied are you with your:										
Career	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Current job	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Level of education	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Creativity	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Personal finances	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10
Over the past month, how would you describe your ability to focus and think clearly?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor									
Over the past year, how often have you felt that interesting and challenging situations fill your life?	<input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Most of the time <input type="checkbox"/> Almost Always									
In the past year, how many days have you missed of work due to personal illness or injury?	<input type="text"/> <input type="text"/> <input type="text"/> days									
How much stress do you feel over finances?	<input type="checkbox"/> Little or none <input type="checkbox"/> Moderate <input type="checkbox"/> Severe									
As of today, are you on track to have adequate financial resources to retire at age 65?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know									

MY HEALTH INTERESTS



What are some of the things that you want to have more of in your life: (please check all that apply)

Confidence	Leisure time
Creativity	Recreation / sports
Energy	Social life
Focus	Supportive relationships
Fun	Time with family
Intimacy	Other: <i>(please describe)</i>
Joy & laughter	Other: <i>(please describe)</i>

Which of the following topics are you interested in?

Living an overall healthy lifestyle	Disease management <i>(i.e. diabetes, cholesterol)</i>
Nutrition/healthy eating	Stress reduction & managing emotions
Weight management	Changing my thinking to be less worried or depressed
Enjoyable physical activity	Better relationships at work and at home
Improving sleep	Having more energy and/or feeling less "stuck"
Reducing cancer risk	Financial wellness <i>(i.e. budgeting, debt elimination)</i>
Hormone health	Professional development <i>(i.e. leadership, time mgmt)</i>
Smoking cessation	Personal growth <i>(i.e. confidence, sense of purpose,)</i>

In closing, please indicate your general feelings about changing your health habits at the present time, bearing in mind that true health is not just diet & exercise, but also includes things like meaningful relationships, coping with stress, and achieving stable financial wellness...

- I'm not really interested in making any personal changes right now
- I've been thinking about making changes & looking for the right opportunity
- I'm ready to make changes in the immediate future
- I recently made changes and could use help maintaining them
- I've been making optimal health choices for 12 months or more

THANK YOU FOR YOUR TIME TODAY!

Be sure to turn in this survey to Attentive Health **as soon as possible**. If you are not able to return this to us at an onsite meeting you can send it to us via mail, email or fax:

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 Telford, PA 18969
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If you have any questions, please call Attentive Health at 877.875.0333 or email millers@attentivehealth.com.

