



Please note: This is a sample of Kaiser Permanente's (KP's) comprehensive health assessment. Not all questions, such as injury prevention and safety, are shown in the sample.

Our members who use KP's confidential online health assessment as part of the PEBB Health Engagement Model (HEM) program in 2012 won't need to answer every question for their assessment to be counted as complete. The only required questions are gender, age, how much physical activity you get, whether you smoke, and whether you want to send the results to your KP medical record. However, KP's assessment is very interactive. The more questions you answer, the more personalized feedback and encouragement you get both while you are filling out the questionnaire and in the prevention plan you will get when you finish it.

Following the sample assessment
is discussion on the Total Health Assessment
Data Sharing agreement and Medical Record opt in.

succeed

A LIFESTYLE MANAGEMENT PROGRAM DESIGNED ESPECIALLY FOR YOU

What does good health mean to you? Each of us has a unique idea of what good health means because health is a very personal matter. In many ways our health can and does shape who we are now and who we will be in the future. No one wants poor health. But many of us do things that can make us unhealthy, sometimes unknowingly.

It is human nature for us to want to understand ourselves better. At one time or another, nearly everyone has asked.

- “HOW HEALTHY AM I?”
- “AM I AT RISK?”
- “COULD I BE HEALTHIER?”
- “HOW CAN I REDUCE MY RISK?”

HealthMedia Succeed[®] will help you understand what steps you can take to improve or maintain your health by creating a personal healthy lifestyle plan just for you. Your personal plan is based on the answers you provide in this questionnaire. The better we understand you, the better we can create a plan to meet your needs. It is best if you answer all the questions so we can give you a complete plan. However, if a question is marked “optional”, or if you prefer not to answer, you may skip that question. HealthMedia[®] will only share your questionnaire responses as described in the privacy policy. Please see the privacy policy on the back cover.



It's easy to participate in HealthMedia Succeed[®]. Start by completing this questionnaire, which takes most people about 20 minutes. You'll receive your own personal healthy lifestyle plan about two weeks after you mail in your completed questionnaire. In addition, you may be asked to complete a few short feedback surveys throughout the program. Your opinions will help us make sure we are offering the best program possible to meet your needs.



Complete the HealthMedia Succeed[®] questionnaire today, and take control of your personal health.

Let's get started!

GETTING STARTED...

1. Answer all questions as honestly as possible.
2. It is best if you answer all the questions so we can give you a complete plan. However, if a question is marked “optional”, or if you prefer not to answer, you may skip that question.
3. Use a black pen to complete your responses.

- Shade circles or check boxes completely  

- Fill all boxes and  ft  in print clearly

4. Return the questionnaire in the enclosed reply envelope.

Note: By submitting this questionnaire to HealthMedia, Inc. you are giving HealthMedia, Inc. permission to disclose your personal information to your health plan. See back cover for more information.



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Shade response
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About You

RESPONSE REQUIRED

1. **Date of Birth** Example: 01/31/1970

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2. **Gender**

- Male
- Female

3. **What is your ethnicity? Select one.**

- White, Non-Hispanic
- Black or African-American
- Hispanic
- Asian
- Pacific Islander
- Native American Indian or Native Alaskan
- Native Hawaiian
- Multi-racial
- Other

4. **Who lives in your household? Select all that apply.**

- Child(ren) under 2 years old
- Child(ren) between 2 and 12 years old
- Teen(s) between 13 and 18 years old
- Other adult(s)
- I live alone.

5. **What is your current marital status? Select one.**

- Married
- Divorced
- Widowed
- Separated
- Never married
- Unmarried couple living together

6. **What is the highest grade or year of school you completed?**

- Never attended school
- Elementary
- Some high school
- High school/GED
- Some college or tech school
- College grad or higher

7. **Have you ever been diagnosed with any of the following? Select all that apply.**

- Heart attack
- Angina
- High blood pressure
- Coronary Heart Disease
- Congestive Heart Failure
- Other Heart Disease
- Stroke
- TIA (mini-stroke lasting less than 24 hrs)
- PVD (Peripheral Vascular Disease)
- Emphysema
- Chronic bronchitis
- Asthma
- Colorectal cancer
- Skin cancer
- Breast cancer
- Cervical cancer
- Prostate cancer
- High cholesterol
- High blood sugar
- Hepatitis B
- STD (sexually transmitted disease)
- Diabetes (Sugar)
- Metabolic Syndrome
- Obesity
- Osteoporosis
- Chronic pain (e.g., arthritis, migraine, fibromyalgia, neuropathy)
- Back pain
- Depression
- Insomnia
- None of the above



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Quality of Life & Health

1. Would you say that in general your quality of life is:

- Excellent
- Very good
- Good
- Fair
- Poor

2. Would you say that in general your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

3. Compared to others like you, how would you rate your own health?

- Much better than average
- Better than average
- Average
- Worse than average
- Much worse than average

Not for completion or submission



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Weight Management

1. How tall are you (to nearest inch, e.g., 6 ft, 00 in)?

feet inches

2. How much do you weigh (to the nearest pound)?

pounds

3. What is your waist measurement (to the nearest inch, measured between the lowest ribs and the top of the hips)?

inches

4. Which of the following statements best describes your current weight management status?

- I have not been actively trying to manage my weight and don't intend to begin doing so in the next 6 months.
- I have not been actively trying to manage my weight but intend to begin doing so in the next 6 months.
- I have recently (within 30 days) begun actively trying to manage my weight but have done so inconsistently.
- I have been actively trying to manage my weight but for less than 6 months.
- I have managed my weight for 6 months or more.

5. Currently, how motivated are you to manage your weight?

Not At All Motivated											Extremely Motivated	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

6. Currently, how confident are you that you can manage your weight?

Not At All Confident											Extremely Confident	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

7. Using the scale below as a guide, please rate how confident you are that you can manage your weight when:

Not Confident						Extremely Confident
	1	2	3	4	5	

- a. you are upset or angry.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- b. it's the holiday season or you are on vacation.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- c. you eat out a lot.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- d. you are tired or stressed.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- e. you don't exercise regularly.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- f. you are lonely or bored.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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Not for completion or submission



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Physical Activity

1. Have you been told by a doctor or other health care professional that you should not engage in physical activity?

- Yes  SKIP to next section (Nutrition)
- No

2. Is at least ONE of the following statements true for you?

- Your doctor has said that you have a heart condition and that you should only do physical activity recommended by a doctor.
- You feel pain in your chest when you do physical activity.
- In the past month, you had chest pain when you were not doing physical activity.
- You lose your balance because of dizziness or you ever lose consciousness.
- You have a bone or joint problem (for example, back, knee, or hip) that could be made worse by a change in your physical activity.
- Your doctor is currently prescribing drugs (for example, water pills) for your blood pressure or heart condition.
- There is any other reason why you should not do physical activity.

- Yes
- No

The following questions will attempt to assess how many minutes of physical activity you get in a typical week. Please answer each question with the days per week and minutes per day for your activity. For activities you do not engage in, please select "0" for both days and minutes.

3. Based on the descriptions on the right, on average, how many days per week do you perform:

Moderate-intensity activity days per week

High-intensity activity days per week

4. On the days you do physical activity, what is the average amount of time you spend doing:

Moderate-intensity activity minutes per day

High-intensity activity minutes per day

Low-intensity physical activity: You should be able to sing while doing these activities and may notice a slight increase in your heart rate.

- Examples:
- slow walking
 - golfing with a cart
 - dusting or vacuuming
 - light stretching

Moderate-intensity physical activity: You should be able to have a conversation during these activities, but will have an increase in breathing, increase in heart rate, and light sweating.

- Examples:
- brisk walking
 - casual swimming
 - mowing with a power motor

High-intensity physical activity: You should be too out of breath to hold a conversation when doing these activities. There will also be a large increase in heart rate and breathing.

- Examples:
- running
 - bicycling
 - swimming laps
 - weight circuit training



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5. In a typical week, how often do you perform strengthening or weight lifting exercises (e.g., push-ups, pull-ups, sit-ups, lifting free weights, or using weight machines)?

- Rarely or never
- 1 or 2 times a week
- 3-5 times a week
- 6-7 times a week

6. In a typical week, how often do you stretch or perform range of motion exercises (e.g., stretching, yoga, or tai chi)?

- Rarely or never
- 1 or 2 times a week
- 3-5 times a week
- 6-7 times a week

7. Exercise includes activities such as brisk walking, jogging, swimming, aerobic dancing, biking, rowing, etc. Regular exercise equals at least 30 minutes of activity most days of the week.

Based on this definition of regular exercise, which of the following statements best describes your current exercise habits?

- I currently do not exercise regularly and do not intend to start in the next 6 months.
- I currently do not exercise regularly but am thinking about starting to exercise in the next 6 months.
- I have recently (within the last 30 days) begun to exercise but do so inconsistently.
- I currently exercise regularly but have only begun to do so in the past 6 months.
- I currently exercise regularly and have done so for 6 months or more.

8. Currently, how motivated are you to increase your physical activity?

Not At All Motivated											Extremely Motivated	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

9. Currently, how confident are you that you can increase your physical activity?

Not At All Confident											Extremely Confident	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

10. Using the scale below as a guide, please rate how confident you are that you can be physically active when:

Not Confident	Somewhat Confident	Confident	Very Confident	Extremely Confident
1	2	3	4	5

- a. you don't have someone to exercise with.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- b. you feel tired.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- c. you haven't been exercising regularly.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- d. you can't find an activity you enjoy.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- e. the weather is poor.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- f. your schedule is inconsistent.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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Nutrition

1. Do you for any reason NOT eat foods from one or more of the following groups? *Select all that apply.*

- Dairy
- Eggs
- Poultry
- Beef
- Pork or ham
- Lamb
- Fish
- Shellfish
- Grains
- Nuts
- Gluten
- None of the above

2. On most days, how many servings of grain products do you eat, such as bread, rice, pasta? (1 serving of grains = 1 ounce)

What counts as 1 ounce?

1/2 cup cooked rice
 1/2 cup cooked pasta
 1 slice of bread
 1 pancake
 1 packet of cooked cereal
 1 small flour tortilla
 1 mini bagel

- None
- 1-2 servings
- 3-4 servings
- 5 servings
- 6 servings
- 7 servings
- 8 servings
- 9 servings
- 10 servings
- More than 10 servings

3. On most days, how many of your grain servings are made from whole grain?

Whole Grain Examples:

Cereals: bran, shredded types, fruit with fiber types, oat bran, oatmeal

Breads: whole wheat, rye, and pumpernickel

Rice: brown rice

Other: whole grains

- None
- Less than half
- Half
- More than half
- All

4. On most days, how many servings of meat, poultry, fish, beans, eggs, and/or nuts, do you eat? (1 serving of meat, poultry, fish, beans, eggs, and/or nuts = 1 ounce)

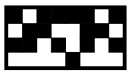
Examples of common meat, poultry, and or fish portions are often more than 1 ounce:

1 small steak = 3 1/2-4 ounces
 1/2 chicken breast = 3 ounces
 1 can of tuna, drained = 3-4 ounces

Others:

1 egg
 1/4 cup dry beans or dry peas

- None
- 1-2 servings
- 3-4 servings
- 5 servings
- 5 1/2 servings
- 6 servings
- 6 1/2 servings
- 7 servings
- More than 7 servings



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5. On most days, how many cups of vegetables do you eat?

What counts as 1 cup of vegetables?

12 baby carrots
3 spears of broccoli, 5" long, raw or cooked
2 cups raw leafy greens
1 medium baked potato
1 large ear of corn (8"-9" long)

- None
- 1 cup
- 1 1/2 cups
- 2 cups
- 2 1/2 cups
- 3 cups
- 3 1/2 cups
- 4 cups
- More than 4 cups

6. On most days, how many cups of fruit do you eat?

What counts as 1 cup of fruit?

8 large strawberries
32 seedless grapes
1 small apple
1 large orange
1 large banana (8"-9" long)

- None
- 1 cup
- 1 1/2 cups
- 2 cups
- 2 1/2 cups
- More than 2 1/2 cups

7. On most days, how many cups of calcium-rich foods (such as milk, cheese) do you eat?

What counts as 1 cup of calcium-rich foods?

8 ounces of milk
1 8-ounce container of yogurt
2 slices of hard cheese
2 cups of cottage cheese

- None
- 1 cup
- 2 cups
- 3 cups
- More than 3 cups

8. On most days, how many total servings of soft margarine, mayonnaise, oil, or salad dressing do you eat? (1 serving of oil = 1 teaspoon)

Common portions of foods containing more than 1 teaspoon of oil:

1 tbsp of soft margarine = 2 1/2 tsp of oil
1 tbsp of mayonnaise = 2 1/2 tsp of oil
1 tbsp of vegetable oil = 3 tsp of oil
2 tbsp of salad dressing = 2 tsp of oil

- Less than 5 servings
- 5 servings
- 6 servings
- 7 servings
- 8 servings
- 9 servings
- 10 servings
- 11 servings
- More than 11 servings



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9. On most days, how many servings of foods high in saturated or trans fats do you eat (including foods made with butter, lard, shortening, or solid margarine)?

Examples:

baked goods or desserts	ice cream
regular cheeses	bacon
whole milk or cream	fried foods

- None
- 1 serving
- 2 servings
- 3 servings
- 4 or more servings

10. The daily recommendation for a healthy diet is:

5-10 ounces of bread, cereal, pasta, or rice
 2-4 cups of vegetables
 1 1/2 - 2 1/2 cups of fruit
 3 cups of milk, yogurt, cheese
 5-7 ounces of meat, poultry, fish, dry beans, eggs or nuts
 5-11 tsp of oils (unsaturated fats)
 Limited amounts of saturated and trans fats

Based on this recommendation, which statement best describes your current eating habits?

- I do not meet this recommendation and do not intend to meet it in the next 6 months.
- I do not meet this recommendation but am thinking about meeting it in the next 6 months.
- I have recently (within 30 days) begun to meet this recommendation but do so inconsistently.
- I meet this recommendation but have only begun doing so in the past 6 months.
- I meet this recommendation and have been doing so for 6 months or more.

11. In general, which best describes your eating habits concerning salt or sodium?

- I rarely cook with salt or add it at the table AND I rarely eat processed foods (lunch meat, canned vegetables) or salted snacks (chip, pretzels).
- I use salt sparingly in cooking and taste foods before salting them, AND/OR I occasionally eat processed foods or salted snacks (3 times a week or less).
- I use salt liberally in cooking and at the table, AND/OR I eat processed foods or salted snacks almost daily.

12. Currently, how motivated are you to improve your eating habits?

Not At All Motivated											Extremely Motivated
0	1	2	3	4	5	6	7	8	9	10	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

13. Currently, how confident are you that you can improve your eating habits?

Not At All Confident											Extremely Confident
0	1	2	3	4	5	6	7	8	9	10	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

14. Using the scale below as a guide, please rate how confident you are that you can follow a healthy diet when:

Not Confident	Somewhat Confident	Confident	Very Confident	Extremely Confident
1	2	3	4	5

- a. you are around others who don't follow healthy diets.
 1 2 3 4 5
- b. you are tired and don't feel like preparing a healthy meal.
 1 2 3 4 5
- c. you eat out frequently.
 1 2 3 4 5
- d. you feel the need to reward yourself with food.
 1 2 3 4 5
- e. you are around tempting desserts or fast foods.
 1 2 3 4 5
- f. you haven't had time to shop for groceries.
 1 2 3 4 5



Fill ALL boxes and print clearly

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Tobacco

1. Do you currently use any of the following tobacco products? *Select all that apply.*

- Cigars
- Pipe
- Chewing tobacco
- Snuff
- No, I do not currently use any of these items.

2. Which of the following statements best describes your current cigarette smoking status?

- I have never smoked cigarettes. SKIP to next section (Stress & Well-being)
- I currently smoke cigarettes and do not intend to quit in the next 6 months.
- I currently smoke cigarettes but am thinking of quitting in the next 6 months.
- I currently smoke cigarettes but intend to quit within the next 30 days and have quit for at least 24 hours in the past year.
- I have quit smoking cigarettes within the last 6 months. SKIP to next section (Stress & Well-being)
- I have quit smoking cigarettes for more than 6 months. SKIP to next section (Stress & Well-being)

3. How many cigarettes per day do you smoke, on average?

4. How many years have you smoked cigarettes?

5. How soon after you wake up do you smoke your first cigarette?

- Within 5 minutes
- Within 6-30 minutes
- Within 31-60 minutes
- After 60 minutes

6. What is the longest period of time you have quit?

- I have never tried to quit
- At least 1 day but less than 2 weeks
- At least 2 weeks but less than 3 months
- At least 3 months but less than 1 year
- At least 1 year

7. Currently, how motivated are you to quit smoking?

Not At All Motivated											Extremely Motivated	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

8. Currently, how confident are you that you can quit smoking?

Not At All Confident											Extremely Confident	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

9. Using the scale below as a guide, please rate how confident you are that you can keep from smoking cigarettes when:

Not Confident	Somewhat Confident	Confident	Very Confident	Extremely Confident
1	2	3	4	5

- a. you feel you need a lift.

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- b. you feel stressed.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- c. you feel angry.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- d. you feel bored.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- e. you have a physical craving for a cigarette.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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- f. you feel you need to control your weight.

<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5
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Stress & Well-being

1. In the last month, how often have you felt nervous or stressed?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

2. In the last month, how often have you been angered because of things that happened that were outside of your control?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

3. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

4. In the last month, how often have you felt confident about your ability to handle your personal problems?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

5. In the last month, how often have you felt that you were on top of things?

- Never
- Almost never
- Sometimes
- Fairly often
- Very often

6. Examples of stress management techniques include:

relaxation	time management
meditation	deep breathing
yoga	learning coping skills
exercise (physical activity)	tai chi

Which statement best describes your current stress management status?

- I do not currently attempt to manage my stress and do not intend to do so in the next 6 months.
- I do not currently attempt to manage my stress but intend to start in the next 6 months.
- I have recently (within the last 30 days) attempted to manage my stress but do so inconsistently.
- I consistently attempt to manage my stress but have done so for less than 6 months.
- I consistently attempt to manage my stress and have done so for 6 months or more.

7. Currently, how motivated are you to practice stress management techniques?

Not At All Motivated											Extremely Motivated	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

8. Currently, how confident are you that you can manage your stress?

Not At All Confident											Extremely Confident	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	



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completely



9. Using the scale below as a guide, please rate how confident you are that you can:

Not Confident	Somewhat Confident	Confident	Very Confident	Extremely Confident
------------------	-----------------------	-----------	-------------------	------------------------

1	2	3	4	5
----------	----------	----------	----------	----------

- a. reduce stress in your life.
 1 2 3 4 5
- b. practice stress management techniques consistently.
 1 2 3 4 5
- c. practice stress management techniques even when demands on your time increase.
 1 2 3 4 5
- d. find support for the changes you are making.
 1 2 3 4 5
- e. set reasonable limits despite other people's demands.
 1 2 3 4 5
- f. remove yourself from stressful situations.
 1 2 3 4 5

10. Are you currently being treated for depression or bipolar disorder by a psychiatrist, psychologist, or other health professional?

- Yes SKIP to next section (Sleeping Habits)
- No
- Prefer not to answer

You may have experienced some of the following situations. Please indicate if you experienced the given situations during the past week.

11. During the past week, I felt depressed.

- Rarely or none of the time (less than 1 day)
- Some or little of the time (1-2 days)
- Occasionally or a moderate amount of time (3-4 days)
- Most or all of the time (5-7 days)

12. During the past week:

- a. I felt that people disliked me.
 Yes No
- b. I was happy.
 Yes No
- c. I felt that everything I did was an effort.
 Yes No
- d. my sleep was restless.
 Yes No
- e. I felt lonely.
 Yes No
- f. people were unfriendly.
 Yes No
- g. I enjoyed life.
 Yes No
- h. I felt sad.
 Yes No
- i. I could not get "going."
 Yes No

13. Using the scale below as a guide, if you were to find yourself depressed, please rate how confident you are that:

Not Confident	Somewhat Confident	Confident	Very Confident	Extremely Confident
------------------	-----------------------	-----------	-------------------	------------------------

1	2	3	4	5
----------	----------	----------	----------	----------

- a. you would know where/how to get help.
 1 2 3 4 5
- b. you could find a caring professional to talk with.
 1 2 3 4 5
- c. your concerns would be kept confidential.
 1 2 3 4 5
- d. you could follow through with the treatment being offered.
 1 2 3 4 5
- e. you could benefit from the professional treatment that you receive.
 1 2 3 4 5
- f. you have a good support system to help you with this process (friends, family, clergy, doctor, therapist, etc.).
 1 2 3 4 5



Fill ALL boxes
and print clearly

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Shade response
completely



Sleeping Habits

1. How many hours of sleep do you usually get in a 24-hour period?

- 6 hours or less
- 7 hours
- 8 hours
- 9 hours or more

2. Please rate the quality of your sleep.

Very poor Excellent

0 1 2 3 4 5 6 7 8 9 10

3. How would you best describe your sleep? *Select all that apply.*

- I have difficulty falling asleep.
- I have difficulty staying asleep.
- I wake too early.
- I still feel tired even after 6 or more hours of sleep.
- I don't have any problems sleeping.

4. Currently, how motivated are you to improve your sleep?

Not At All Motivated Extremely Motivated

0 1 2 3 4 5 6 7 8 9 10

5. Currently, how confident are you that you can improve your sleep?

Not At All Confident Extremely Confident

0 1 2 3 4 5 6 7 8 9 10

Eating Habits

1. Do you ever eat what other people would consider an unusually large amount of food?

- Yes
- No SKIP to next section (Alcohol)

2. In the past month, how many times have you eaten what other people would consider an unusually large amount of food?

3. In the past month while eating, was there ever a time that you felt you lost control over your eating?

- Yes
- No

4. In the past month, how many times did you feel you lost control of your eating?



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Fill ALL boxes and print clearly

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Shade response completely



Alcohol

These questions are about drinking alcoholic beverages. Included are beer, wine, and liquor.

If you are pregnant, please answer the following questions about alcohol with your CURRENT use in mind.

One drink equals :

- one 12 oz. beer
- one 5 oz. glass of wine
- one shot (1.5 oz.) of liquor

1. On average, how often do you have a drink containing alcohol?

- Never. I do not drink. SKIP to next section (Skin Protection)
- Less than once a month
- Once a month
- 2-3 days a month
- 1-2 days a week
- 3-4 days a week
- Nearly every day

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

drinks per day

3. For the question that follows, please use this information:

- For women of all ages and men over age 65, binge drinking is defined as 4 or more drinks in about 2 hours or less.
- For men age 65 and younger, binge drinking is defined as 5 or more drinks in about 2 hours or less.

How often do you binge drink?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

4. The National Institutes of Health recommends

consuming no more than 1 drink a day for women of all ages, 1 drink a day for men over age 65, and 2 drinks a day for men age 65 and younger. Pregnant women should not drink any alcohol.

Which of the following statements best describes your current alcohol use?

- I drink more than the recommended amount and do not intend to drink less in the next 6 months.
- I drink more than the recommended amount but do intend to drink less in the next 6 months.
- In the last 30 days I have begun to drink less, but I am doing so inconsistently.
- I drink within the recommended amount but have done so for less than 6 months.
- I drink within the recommended amount and have done so for 6 months or more.

5. Currently, how motivated are you to reduce your alcohol consumption?

Not At All Motivated												Extremely Motivated
0	1	2	3	4	5	6	7	8	9	10		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

6. Currently, how confident are you that you can reduce your alcohol consumption?

Not At All Confident												Extremely Confident
0	1	2	3	4	5	6	7	8	9	10		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		

7. Using the scale below as a guide, please rate how confident you are that you can limit the amount you drink when:

Not Confident	Somewhat Confident	Confident	Very Confident	Extremely Confident
1	2	3	4	5

- a. you are feeling depressed or worried.
 1 2 3 4 5
- b. you are on vacation and want to relax.
 1 2 3 4 5
- c. you are angry or frustrated.
 1 2 3 4 5
- d. you are socializing with your friends or co-workers.
 1 2 3 4 5
- e. you are at a bar or party.
 1 2 3 4 5
- f. you are alone.
 1 2 3 4 5



Fill ALL boxes and print clearly

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Shade response completely



Skin Protection

1. When you go outside on a very sunny day for more than 15 minutes, how often do you:

a. wear protective clothing such as wide-brimmed hats or long-sleeved shirts?

- Seldom or never
- Some of the time
- Most of the time
- Always

b. avoid the sun by staying in the shade?

- Seldom or never
- Some of the time
- Most of the time
- Always

c. use sunscreen of SPF 15 or higher?

- Seldom or never
- Some of the time
- Most of the time
- Always

2. After several months of not being in the sun, if you then went out in the sun without sunscreen or protective clothing for an hour, which one of these would happen to your skin? *Select one answer.*

- Severe sunburn with blisters
- Severe sunburn for a few days with peeling
- Mildly burned with some tanning
- Turning darker without sunburn
- Nothing would happen in an hour
- Other
- Don't know

3. If you were out in the sun for a long time repeatedly, which of these things would happen to your skin? *Select one answer.*

- Very dark and deeply tanned
- Moderately tanned
- Mildly tanned
- Only freckled
- No change
- Repeated sunburns
- Other
- Don't know

4. In your opinion, how sensitive is your skin to sunlight?

- Extremely sensitive
- Moderately sensitive
- Mildly sensitive
- Not sensitive at all
- Don't know

5. Currently, how motivated are you to improve your skin protection habits whenever you are outdoors?

Not At All Motivated											Extremely Motivated	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

6. Currently, how confident are you that you can improve your skin protection habits whenever you are outdoors?

Not At All Confident											Extremely Confident	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

7. Using the scale below as a guide, please rate how confident you are that you can :

Not Confident	Somewhat Confident	Confident	Very Confident	Extremely Confident
1	2	3	4	5

a. consistently use sunscreen of SPF of 15 or higher when exposed to the sun for more than 15 minutes.

1 2 3 4 5

b. protect your skin when participating in outdoor activities.

1 2 3 4 5

c. stay in the shade when you are without protective clothing or sunscreen.

1 2 3 4 5

d. avoid sun exposure between 10 a.m. and 4 p.m.

1 2 3 4 5

e. check your skin monthly for changes.

1 2 3 4 5



Fill ALL boxes
and print clearly

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Shade response
completely



Immunizations & Health Screenings

1. Have you had these immunizations (shots)?

a. MMR (measles/mumps/rubella) vaccine

Yes No Don't know

b. Hepatitis B vaccine (series of 3 shots)

Yes No Don't know

c. Pneumonia vaccine

Yes No Don't know

d. Tetanus vaccine within the last 10 years

Yes No Don't know

e. Influenza (flu) vaccine within the last 12 months

Yes No Don't know

f. Have you had chickenpox, or had the vaccination?

Yes No Don't know

If you are age 60 or older please answer the following question, otherwise SKIP to the next question.

g. Have you had the shingles vaccine?

Yes No Don't know

Select the appropriate choice for each test or exam question.

h. Have you had a colonoscopy within the last 10 years (tube inserted in rectum to check entire large intestine)?

Yes No Don't know

If yes, SKIP to 2a.

i. Have you had a fecal occult blood test within the last 12 months (stool examined for blood)?

Yes No Don't know

j. Have you had a sigmoidoscopy within the last 5 years (tube inserted in rectum to check for lower intestinal problems)?

Yes No Don't know

k. Have you had a double-contrast barium enema (large intestine X-ray) within the last 5 years to screen for cancer of the colon or rectum?

Yes No Don't know

2. a. When was the last time you had your blood pressure checked?

Less than 1 year ago

1 to 2 years ago

More than 2 years ago

Don't know

b. What were your blood pressure numbers? (For example: 120 over 080)

over

Don't know

c. Have you had your cholesterol checked within the last 5 years?

Yes No Don't know

SKIP to question h

d. What was your total cholesterol number?

Don't know

e. What was your HDL cholesterol number?

Don't know

f. What was your LDL cholesterol number?

Don't know

g. What was your triglyceride number?

Don't know



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Fill ALL boxes
and print clearly

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Shade response
completely



h. Have you had your blood sugar checked within the last 3 years?

- Yes
- No SKIP over next question
- Don't know SKIP over next question

i. What was your blood sugar level?

- Fasting
- Non-fasting
- Don't know my blood sugar level

Women only:

a. Select the appropriate answer regarding pregnancy:

- I am currently pregnant.
- I had a baby within the last 3 months. SKIP to question c
- I am planning on becoming pregnant in the next 6 months. SKIP to question c
- I am not currently pregnant and not planning on becoming pregnant in the next 6 months. SKIP to question c

b. What is your estimated due date?

 / / SKIP to question e

c. Are you currently on hormone therapy (estrogen therapy, Premarin) or planning to start? Select one.

- Yes
- No
- A doctor has advised me not to do this.

d. Have you ever had a total hysterectomy (removal of both uterus and cervix)?

- Yes, because of a diagnosis of cancer of the cervix
- Yes, for a reason other than cancer of the cervix
- Yes, but am unsure of the reason
- No

e. Are you currently breastfeeding?

- Yes
- No

Women only:

f. When was your last Pap Smear?

- Less than 1 year ago
- 1 to 3 years ago
- More than 3 years ago
- Don't know
- I have never had a Pap smear.

g. Have you had a clinical breast exam by a health care provider within the last 12 months?

- Yes
- No
- Don't know

h. When did you last have a mammogram?

- Less than 1 year ago
- 1 to 2 years ago
- More than 2 years ago
- Don't know
- I have never had a mammogram

i. If you are a woman age 26 and under, please answer the following question.

Have you had the HPV vaccine (human papillomavirus vaccine for cervical cancer)?

- Yes
- No
- Don't know

j. If you are a woman age 60 or over, please answer the following question. Otherwise skip to the next page.

Have you ever had a bone density scan?

- Yes
- No
- Don't know



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Fill ALL boxes and print clearly

5 ft 0 0 in

Shade response completely



A Little More About You

1. Please choose the category that best describes your main job.

- Executive, administrator, or senior manager (e.g., CEO, sales VP, plant manager)
- Professional (e.g., engineer, accountant, systems analyst)
- Technical support (e.g., lab technician, legal assistant, computer programmer)
- Sales (e.g., sales representative, stockbroker, retail sales)
- Clerical and administrative support (e.g., secretary, billing clerk, office supervisor)
- Service occupation (e.g., security officer, food service worker, janitor)
- Precision production and crafts worker (e.g., mechanic, carpenter, machinist)
- Operator or laborer (e.g., assembly line worker, truck driver, construction worker)
- Not currently working outside the home (e.g., retired, student, caregiver for children)

SKIP to question 7

2. In the past 12 months, how many days of work have you missed due to illness?

--	--	--

days

3. During the past 4 weeks, how many hours did you miss from work because of your health problems?

Include hours you missed on sick days, times you went in late, left early, etc., because of your health problems. Do not include time you missed to participate in this program.

--	--	--

hours

4. During the past 4 weeks, how many hours did you miss from work because of any other reason, such as vacation or holidays?

--	--	--

hours

5. During the past 4 weeks, how many hours did you actually work?

--	--	--

hours

6. During the past 4 weeks, how much did your health problems affect your productivity while you were working?

Think about the days you were limited in the amount or kind of work you could do, days you accomplished less than you would like, or days you could not do your work as carefully as usual. If health problems affected your work only a little, choose a low number. Choose a high number if health problems affected your activities a great deal.

Health problems had no effect on my work

Health problems completely prevented me from working

0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. During the past 4 weeks, how much did your health problems affect your ability to do your regular daily activities, (other than work at a job)?

By regular activities, we mean the usual activities you do, such as work around the house, shopping, child care, exercising, studying, etc. Think about times you were limited in the amount or kind of activities you could do and times you accomplish less than you would like. If health problems affected your activities only a little, choose a low number. Choose a high number if health problems affected your activities a great deal.

Health problems had no effect on my daily activities

Health problems completely prevented me from doing my daily activities

0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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Fill ALL boxes
and print clearly

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Shade response
completely



Do you want us to tell your current employer that you filled out the Total Health Assessment, in case they have a rewards program?

If your employer's group health plan or Kaiser Permanente offers incentives, rewards, or prizes for completing any of the healthy lifestyle programs, HealthMedia will send your name, address, date of birth, and other enrollment information necessary for issuing the reward to your employer's group health plan and/or Kaiser Permanente, and/or to a rewards administrator so they can send the reward to you or administer a drawing for prizes. HealthMedia will not give your employer any other information about you.

Note: Not all employers offer rewards, drawings, or prizes for completing healthy lifestyle programs.

Your choices:

- Yes, please tell my current employer:** I agree that my name, address, date of birth, and other enrollment information, and the fact that I completed a healthy lifestyle program (but not my answers) can be shared with my employer's group health plan, Kaiser Permanente, and the rewards administrator.
- No, do not tell my current employer:** I decline to share my information and choose not to participate in the rewards program. I understand that I will not be entitled to earn a reward.

Kaiser Permanente Members only:

Do you want us to file your results in your Kaiser Permanente medical chart?

If you give your consent, HealthMedia will share the results of your Succeed Health Risk Assessment (Total Health Assessment) with Kaiser Permanente. Some of your results will become part of your electronic medical record (your chart), which can be viewed by your doctor and by other appropriate members of Kaiser Permanente's health staff. Your Health Risk Assessment information may then be used for research or quality improvement purposes, as well as for your medical care.

In all cases, every effort will be made to protect the privacy of your information. We will keep any of your information that is not in your electronic medical record in secure, encrypted databases that remain within Kaiser Permanente. Only a very limited number of Kaiser Permanente staff will have access. Reports resulting from the research would never identify you personally, but only describe whole groups of members.

If you do not give your consent, HealthMedia will not share these results with Kaiser Permanente. Your decision not to consent will not affect your health care or your ability to participate in the Succeed Health Risk Assessment or other healthy lifestyle programs in any way.

Your choices:

- Yes, please put my Total Health Assessment results in my chart:** I agree that the results of my Succeed Health Risk Assessment (Total Health Assessment) may be shared with Kaiser Permanente and filed in my electronic medical record.
- No, do NOT put my Total Health Assessment results in my chart:** I do not give permission to share my information with Kaiser Permanente. My doctor and others who may want to see my Total Health Assessment results will not be able to view them in my electronic medical record.

BY FILLING OUT AND RETURNING THIS QUESTIONNAIRE YOU ARE AGREEING TO THE FOLLOWING TERMS.

HealthMedia® is committed to the privacy and confidentiality of personal information. HealthMedia® recognizes that the security of your health care information is of great concern to you. Any health information you have provided to HealthMedia that is linked with an identifier, such as your name, is defined as personal health information.

By participating in a HealthMedia® program you will receive a tailored behavior change intervention guide. In order to provide you with an accurate and useful tailored personal guide, HealthMedia® asks for the minimally necessary information which includes your name, address, and relevant health history along with information about lifestyle behaviors such as smoking and exercise, physical measurements such as height, weight, and blood pressure, and mental health topics. Your answers form the basis of the personal guide that is unique to you. In conjunction with the personal guide you may also receive follow-up newsletters and communications. Communications will be sent out to the address you provide. These communications may contain information about your condition or disease state.

HealthMedia® may disclose your personal health information to your health plan without specific authorization or as required by law. Your health plan will disclose your participation in this program to your employer if your employer offers an incentive. Your health plan may disclose to your employer aggregate data that will not contain any information which discloses your identity, for purposes of helping the employer understand the needs and characteristics of their employee population. In addition, HealthMedia® may create aggregate data results for dissemination to other organizations and for research purposes. Aggregate data is data combined from many individuals. THIS AGGREGATE DATA WILL NOT CONTAIN ANY INFORMATION WHICH DISCLOSES YOUR IDENTITY. In this case, your data is combined with data of other participants to determine an overall profile of a population. These data become statistics and may be used by HealthMedia®, your health plan, or other organizations to understand the needs and characteristics for selected populations.

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CUSTOMER SERVICE

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ADMIN@HEALTHMEDIA.COM

PLEASE NOTE: The information, data, behavioral recommendations, and any other materials provided by HealthMedia, Inc. in the questionnaire, digital consultation, plan, newsletters, website, and in any other form are not, nor are they intended to be, a medical evaluation, examination, advice, consultation, diagnosis, or treatment. HealthMedia, Inc. recommends that you consult a physician or other health care provider for all medical and health-related matters. HealthMedia, Inc. and its licensors will not be liable for, and you waive any claim for, any personal injury, damage, and/or liability arising out of your use of or your reliance on the information, data, behavioral recommendations, and any other materials made available to you by HealthMedia, Inc.

Kaiser Permanente HealthMedia Succeed total health assessment Data sharing agreement & Medical Record opt-in

Succeed total health assessment data sharing agreement

[When a user signs in to take the HealthMedia Succeed™ total health assessment, or any of the healthy lifestyle programs, the user must accept the following disclosure terms to access the programs]

Disclosure Statement

Note: The data sharing statement was updated on 9/27/11. All data received from your previous submissions, will be shared according to your data sharing statement in effect at that time. Before you can access the programs, you must agree to the data sharing statement below.

By clicking the “I agree” button below and participating in the Succeed™ total health assessment or any healthy lifestyle program (also known as digital coaching programs), I agree to the following terms:

- I understand that my specific health information, such as responses to the health-related questions asked in the Succeed™ total health assessment or in any of the healthy lifestyle programs, and any health concern or condition implied by participation in any specific healthy lifestyle program, will be kept confidential within HealthMedia, Inc. and Kaiser Permanente. HealthMedia, Inc. and Kaiser Permanente will not disclose this information without my permission unless permitted by law and as described in the privacy policy.
- I understand that some —but not all—employers and group health plans offer rewards, such as incentives, raffles, or prizes, for completing the Succeed™ total health assessment and/or healthy lifestyle programs. Check with your employer to find out if you have one available to you.
- If my organization offers rewards, I understand that my name, address, the fact that I took a Succeed™ total health assessment and the date of completion and /or the date(s) of completion and the number of healthy lifestyle programs I took may be shared with my employer and/or a reward administrator (my specific health information will not be disclosed). **I understand that that if I do not agree to the use and disclosure of this information for the purposes of reward administration, that I cannot take the Succeed™ total health assessment or any of the healthy lifestyle programs.**
- In addition, HealthMedia or Kaiser Permanente may provide my employer aggregate information as part of a group summary report (my specific health information will not be disclosed). An aggregate report means that no individual can be identified in the report.

BUTTON: I agree to the use of my individual data as outlined above.

**Kaiser Permanente HealthMedia Succeed total health assessment
Data sharing agreement & Medical Record opt-in**

ELECTRONIC MEDICAL RECORD OPT-IN QUESTION

Member medical record opt-in screen

[The user finishes a HealthMedia Succeed™ total health assessment and then receives a screen with the following information for electronic medical record opt-in]

Good health is a team sport

If you'd like to get your health care team involved, you can have your Succeed™ total health assessment (Succeed™ THA) responses added to your electronic medical record. That way, your Succeed™ THA information will be available to your doctor and others for your health care.

However, whether you choose yes or no, Kaiser Permanente may use or disclose your Succeed™ THA results and other Protected Health Information as permitted or required by law for other purposes, such as quality assurance and research.

- YES, add my Succeed™ THA results to my Kaiser Permanente medical record.
- NO, do not add my Succeed™ THA results to my Kaiser Permanente medical record.

Your decision not to add your Succeed™ THA results to your medical record will not affect your access to health care or your ability to participate in healthy lifestyle programs in any way.