



AT CARE  GUIDE

Your Address for Better Health™

Your Health Profile



AT CARE GUIDE

Your Address for Better Health™

One Care Street®
Support Center
317-489-5886
866-245-2453

Some notes before you begin...

Purpose of this survey

New efforts are underway to help people with their health BEFORE they have a crisis. These types of activities could greatly improve the quality of life for many people, most importantly YOU. The purpose of this survey is to help you look closely at how you currently view your health, identify factors that contribute to your health, and help you discover just the right ways to maintain or improve your health. Since your personalized Health Action Guide will be prepared based on the responses you mark herein, *it is important to answer every question to the best of your ability.* Be truthful with yourself and consider using this as a great first step to a healthier way of life!

Helping you feel your personal best is what One Care Street® is all about!

Here is what you will get as a result of your participation in this Health Profile...

- A look at the health areas where you're doing well and the areas where you may choose to improve
- Expert guidance to choose an area for health improvement that is right for YOU
- A personalized Health Action Guide to help you be successful every step of the way

One Care Street®
is an authorized
service of

CARE GUIDE

www.careguide.com

One Care Street® is "Your Address for Better Health™." By choosing to participate in this Health Profile, you are taking an important step towards feeling better every day!



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Participant Authorization to Obtain and Release Health Information

The primary purposes of the survey are to provide you with an assessment of your health, to assist you in improving your health, and to help manage health care costs by providing earlier assistance for those with significant health concerns.

By signing this Participant Authorization and voluntarily participating in this survey, you authorize CareGuide to obtain, use, and release your survey responses to CareGuide's designated personnel providing the One Care Street® services to you. If you are eligible for additional health coaching and you and your Coach decide you may benefit from additional referred provider services (such as Employee Assistance Program services), your information will be shared with other referred providers, but only with your consent unless required by law (for example, in an emergency situation). Any disclosure to recommended referred providers will only occur after your consent is obtained by telephone confirmation. By signing this authorization, you authorize your name to be released to your sponsoring organization so you can receive your incentive (if applicable) and if you qualify for additional sponsored programs (such as a smoking cessation program), so that you may be notified of such programs. Further, you authorize CareGuide to monitor and record help desk and coaching calls from time to time for quality assurance purposes. CareGuide may also allow de-identified calls to be reviewed for third party evaluation. The survey results and any One Care Street services provided after the survey will not be released to your employer.

You may revoke this authorization by providing written notice to CareGuide at any time. Otherwise, CareGuide will continue to make the survey information available to CareGuide's designated personnel providing the One Care Street services to you for the duration of the services or one year from the date your survey is submitted, whichever is longer. You may contact CareGuide to request and receive a copy of this authorization at any time.

Lastly, by signing this Participant Authorization, you are confirming that you understand what this authorization means, that you are satisfied with any explanations you have requested and received, and that you agree to participate in CareGuide's survey. **Please sign and date this Participant Authorization and include the name of the employer or sponsoring organization participating in this program, where indicated below. We CANNOT process this survey or send you a Health Action Guide unless you sign below.**

Signature _____ Date _____
Employer or Sponsoring Organization _____

Marking instructions:

- Make sure you **complete every question in all sections**.
- Since your personalized Health Action Guide will be prepared based on the responses you mark, ***it is important for you to answer every question to the best of your ability.*** Be truthful with yourself and consider using this as a great first step to a healthier way of life.
- Please use a **#2 pencil** to fill in the best answer.
- **Do not use ink, ball-point, or felt tip pens.**
- Make solid marks that **fill in the bubbles completely.**
- **Cleanly erase** any marks you wish to change.
- Make **no stray marks** on this form.
- Read each question and **follow the instructions.**
- **Do not fold** or wrinkle the survey.
- We welcome additional comments, but please write them on a separate sheet and enclose with your survey. **Do not write your comments on this form.**

We want to thank you in advance for taking the time to take part in your care!

Correct Mark →

Incorrect Marks →



STOP

HAVE YOU COMPLETED ALL THREE ITEMS ABOVE?

Please do not write in this shaded area





Tell us how you're feeling and doing

PLEASE COMPLETE EACH SECTION.

We want to ask you:

How you are feeling and doing—compared with how you *expect to be* feeling and doing? Health is experienced as some level of illness or wellness. For example, a person can feel “well,” feeling good and doing what they are usually able to do, even though he or she may have a disease like diabetes or heart disease. At other times, a person who does not have a disease can feel “ill.”

Tell us how you're feeling

Your physical symptoms

1) This question is about whether you are feeling any of the physical symptoms listed below. Review the list of symptoms and indicate if you have or have not felt any of the symptoms **DURING THE PAST MONTH**.

COMPLETE ALL THREE STEPS BELOW.

STEP 1

Mark only those symptoms you have felt. LEAVE ALL OTHER SYMPTOMS BLANK.

STEP 2

Mark how often you have felt each of the symptoms you marked. 1=Rarely felt, 2=Sometimes felt, 3=Frequently felt, 4=Constantly felt

STEP 3

Mark how much discomfort you have had from each of the symptoms you marked. 1=Slight discomfort, 2=Mild discomfort, 3=Moderate discomfort, 4=Extreme discomfort

1 Which symptoms have you felt IN THE PAST MONTH?

2 How often have you felt this symptom?

3 How much discomfort have you had?

I have NOT FELT any of the symptoms listed below DURING THE PAST MONTH. (Move on to the next page.)

<input type="radio"/> Change in urination habits	1 2 3 4	1 2 3 4
<input type="radio"/> Chest pain/chest discomfort	1 2 3 4	1 2 3 4
<input type="radio"/> Dizziness/light headedness	1 2 3 4	1 2 3 4
<input type="radio"/> Drowsiness	1 2 3 4	1 2 3 4
<input type="radio"/> Headache	1 2 3 4	1 2 3 4
<input type="radio"/> Indigestion	1 2 3 4	1 2 3 4
<input type="radio"/> Nausea/vomiting	1 2 3 4	1 2 3 4
<input type="radio"/> Obvious change in a mole	1 2 3 4	1 2 3 4
<input type="radio"/> Pain other than chest or back pain (including cramping, aching)	1 2 3 4	1 2 3 4
<input type="radio"/> Passing blood in stool	1 2 3 4	1 2 3 4
<input type="radio"/> Persistent back pain	1 2 3 4	1 2 3 4
<input type="radio"/> Persistent constipation	1 2 3 4	1 2 3 4
<input type="radio"/> Persistent coughing/wheezing	1 2 3 4	1 2 3 4
<input type="radio"/> Persistent diarrhea	1 2 3 4	1 2 3 4
<input type="radio"/> Shortness of breath/difficulty breathing	1 2 3 4	1 2 3 4
<input type="radio"/> Skin sore that doesn't heal	1 2 3 4	1 2 3 4
<input type="radio"/> Thickening or lump in breast	1 2 3 4	1 2 3 4
<input type="radio"/> Tired/fatigued/weakness	1 2 3 4	1 2 3 4
<input type="radio"/> Trouble with vision (even while wearing glasses or contacts)	1 2 3 4	1 2 3 4
<input type="radio"/> Unexplained weight loss of more than 10 lbs.	1 2 3 4	1 2 3 4
<input type="radio"/> Unusual bleeding or discharge	1 2 3 4	1 2 3 4

Your medical conditions and how you care for yourself

1) Review the list below and mark any current or past medical conditions, even if you're being treated and/or your condition is under control. If you **DO NOT** have any of the medical conditions listed, mark the "**do not have**" response; **LEAVE ALL OTHERS BLANK** and move on to question 2 on this page.

- I **do not have** any of the medical conditions listed below. (Go to Question 2 on this page.)
- If female, please mark this bubble if you are pregnant.
- | | |
|--|---|
| <input type="radio"/> Allergies | <input type="radio"/> Diabetes or high blood sugar |
| <input type="radio"/> Arthritis | <input type="radio"/> High blood pressure of 140/90 or higher |
| <input type="radio"/> Asthma | <input type="radio"/> Kidney disease |
| <input type="radio"/> Cancer | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Cataracts | <input type="radio"/> Psychiatric illness other than depression |
| <input type="radio"/> Chronic back problems | <input type="radio"/> Seizures or epilepsy |
| <input type="radio"/> Chronic lung disease | <input type="radio"/> Stroke |
| <input type="radio"/> Coronary heart disease, congestive heart failure, angina, heart attack, or heart surgery | <input type="radio"/> Total cholesterol of 240 or higher |
| <input type="radio"/> Deafness | <input type="radio"/> Ulcer or bowel/stomach bleeding |
| <input type="radio"/> Depression | <input type="radio"/> Other _____
(please print clearly) |

2) Overall, how adequately do you feel you are managing your medical condition(s) listed above? (Managing your medical condition(s) adequately means that you understand your condition(s) and participate in your care.) **CHOOSE ONLY ONE.**

- 0 I **do not** currently have a medical condition, so this question does not apply to me.
- 1 More than adequately
- 2 Adequately
- 3 Somewhat adequately
- 4 Not at all adequately

3) When given long-term medication, which statement is most like you? **CHOOSE ONLY ONE.**

- 0 I **have never** been given long-term medications, so this question does not apply to me.
- 1 I remember to take the medicine.
- 2 I usually remember to take the medicine.
- 3 I don't pay much attention unless I get worse.
- 4 I often forget to take my medicine.
- 5 I sometimes stop taking my medicine on my own.
- 6 I usually don't take the medicine at all.

4) How adequately do you feel you are currently managing your long-term medication(s)? ("Adequately" managing your medication(s) means that you understand how to take your medicine(s) and you report how you're doing to your doctor.) **CHOOSE ONLY ONE.**

- 0 I **am not** currently on any long-term medications, so this question does not apply to me.
- 1 More than adequately
- 2 Adequately
- 3 Somewhat adequately
- 4 Not at all adequately

Your emotions

1) DURING THE PAST MONTH, how much have you felt EACH of the following?
PLEASE MARK EVERY EMOTION.

- | | | | | | |
|-------------------|----------------------------------|----------------------------------|----------------------------------|-------------------------------------|---------------------------------|
| Happy | <input type="radio"/> 0 Not felt | <input type="radio"/> 1 Slightly | <input type="radio"/> 2 Somewhat | <input type="radio"/> 3 Quite a bit | <input type="radio"/> 4 Greatly |
| Calm | <input type="radio"/> 0 Not felt | <input type="radio"/> 1 Slightly | <input type="radio"/> 2 Somewhat | <input type="radio"/> 3 Quite a bit | <input type="radio"/> 4 Greatly |
| Afraid | <input type="radio"/> 0 Not felt | <input type="radio"/> 1 Slightly | <input type="radio"/> 2 Somewhat | <input type="radio"/> 3 Quite a bit | <input type="radio"/> 4 Greatly |
| Angry | <input type="radio"/> 0 Not felt | <input type="radio"/> 1 Slightly | <input type="radio"/> 2 Somewhat | <input type="radio"/> 3 Quite a bit | <input type="radio"/> 4 Greatly |
| Depressed | <input type="radio"/> 0 Not felt | <input type="radio"/> 1 Slightly | <input type="radio"/> 2 Somewhat | <input type="radio"/> 3 Quite a bit | <input type="radio"/> 4 Greatly |
| Frustrated | <input type="radio"/> 0 Not felt | <input type="radio"/> 1 Slightly | <input type="radio"/> 2 Somewhat | <input type="radio"/> 3 Quite a bit | <input type="radio"/> 4 Greatly |
| Guilty | <input type="radio"/> 0 Not felt | <input type="radio"/> 1 Slightly | <input type="radio"/> 2 Somewhat | <input type="radio"/> 3 Quite a bit | <input type="radio"/> 4 Greatly |
| Sad | <input type="radio"/> 0 Not felt | <input type="radio"/> 1 Slightly | <input type="radio"/> 2 Somewhat | <input type="radio"/> 3 Quite a bit | <input type="radio"/> 4 Greatly |

Your health care beliefs and preferences

1) Which statement best describes your faith in doctors in general when you are dealing with a medical problem that you aren't sure about? **CHOOSE ONLY ONE.**

- 1 I don't believe what doctors tell me at all.
- 2 I believe what doctors tell me is often wrong.
- 3 I'm not sure if doctors are more often right or wrong.
- 4 I believe what doctors tell me is usually right.
- 5 I believe all of what doctors tell me.

2) Which statement best describes your opinion of the effectiveness and safety of medicine in general? **CHOOSE ONLY ONE.**

- 1 Most medical treatments have not been proven and might be harmful.
- 2 Many medical treatments may have harmful effects we don't know about.
- 3 Some medical treatments haven't been proven, but most are safe.
- 4 Most medical treatments have been proven to be effective and safe.

3) When facing an important medical issue, how often do you seek information from the following sources? **PLEASE MARK EVERY SOURCE.**

Alternative Provider (For example, chiropractor, nutritionist, etc.)

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Computer or Internet services

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Co-workers

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Doctor

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Family

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Friends

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Nurse

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Printed materials

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Telephone information services

- 0 Never 1 Occasionally 2 Sometimes 3 Always

Videos

- 0 Never 1 Occasionally 2 Sometimes 3 Always

4) Please rate your feelings about the following statements: **PLEASE MARK EVERY STATEMENT.**

As you become sicker, you should be told more about your illness.

- 1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

You should be well informed, even if the news is bad.

- 1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

When you are caring for a family member, it is important to understand everything about their illness and treatment.

- 1 Strongly agree 2 Agree 3 Disagree 4 Strongly disagree

5) When you talk to your doctor about a health problem, how much information do you usually receive? **CHOOSE ONLY ONE.**

- 1 Less than I would like
- 2 The right amount
- 3 More than I would like

6) For a minor illness, who should be making decisions about your care? **CHOOSE ONLY ONE.**

- 1 The doctor alone
- 2 Mostly your doctor
- 3 You and your doctor equally
- 4 Mostly you
- 5 You alone

Continued on next page...

Please do not write in this shaded area



Your health care beliefs and preferences, continued...

7) When making a significant decision about health, which statement best describes you? **CHOOSE ONLY ONE.**

- ① I have not yet had to make an important medical care decision.
- ② I take as much time as I need to get several opinions and consider all options before moving ahead.
- ③ I get a few opinions from key people, choose an action and then move ahead.
- ④ I take action as quickly as possible based upon all the information I have at the time.

8) If you were told you had a serious medical condition, how much information would you want to receive? **CHOOSE ONLY ONE.**

- ① None
- ② Very little
- ③ A fair amount
- ④ Quite a lot
- ⑤ All there is to know



Tell us about your health practices

PLEASE COMPLETE EACH SECTION.

1) For each statement below, please tell us whether you *already* do or *intend* to do the following health practices.

- ⑥ No, and I do not intend to improve in the next 6 months.
- ⑤ No, but I intend to improve in the next 6 months.
- ④ No, but I intend to improve in the next 30 days.
- ③ Yes, I have, but for less than 6 months.
- ② Yes, I have for more than 6 months, but less than 5 years.
- ① Yes, I have for 5 or more years.

With respect to your overall lifestyle, do you...

- | | |
|--|-------------|
| a) Wear seat belts whenever you are in a motor vehicle? | ① ② ③ ④ ⑤ ⑥ |
| b) Have your blood pressure checked regularly? | ① ② ③ ④ ⑤ ⑥ |
| c) Have your blood cholesterol checked regularly? | ① ② ③ ④ ⑤ ⑥ |
| d) Get regular health exams appropriate for your gender and age?
(For example, mammograms, pap smears, prostate, rectal exams) | ① ② ③ ④ ⑤ ⑥ |
| e) Use self-care information to avoid unnecessary doctor visits? | ① ② ③ ④ ⑤ ⑥ |
| f) Watch your body for the warning signs of cancer? | ① ② ③ ④ ⑤ ⑥ |
| g) Avoid eating high-fat foods? | ① ② ③ ④ ⑤ ⑥ |
| h) Avoid being overweight? (If you are at or below your ideal weight, mark only #1) | ① ② ③ ④ ⑤ ⑥ |
| i) Exercise moderately at least three times a week for 30 minutes? | ① ② ③ ④ ⑤ ⑥ |
| j) Avoid smoking or tobacco use? (If you have never smoked, mark only #1) | ① ② ③ ④ ⑤ ⑥ |
| k) Get 7 to 8 hours of sleep most days? | ① ② ③ ④ ⑤ ⑥ |
| l) Use measures to protect your back when lifting heavy objects? | ① ② ③ ④ ⑤ ⑥ |
| m) Have a working smoke detector near your sleeping area? | ① ② ③ ④ ⑤ ⑥ |
| n) Have not more than 15 drinks per week if a man or 12 drinks per week if a woman? (If you have never consumed alcohol, mark only #1) | ① ② ③ ④ ⑤ ⑥ |
| o) Avoid driving after having too much to drink, or riding with such a person? | ① ② ③ ④ ⑤ ⑥ |
| p) Avoid using drugs for recreational use? (If you have never used drugs for this reason, mark only #1) | ① ② ③ ④ ⑤ ⑥ |
| q) Have people in your life you can call upon to share problems with or to get help for a few days if needed? | ① ② ③ ④ ⑤ ⑥ |
| r) Cope well with stress on a regular basis? | ① ② ③ ④ ⑤ ⑥ |
| s) Deal well with emotions such as anxiety, fear, guilt, frustration or anger? | ① ② ③ ④ ⑤ ⑥ |
| t) Generally find meaning in your life? | ① ② ③ ④ ⑤ ⑥ |

4

Choose a Health Goal

(Please Note: If you have been instructed by your sponsoring organization to complete a health goal to receive an incentive, this is the section you need to complete!) Think through all the factors affecting how you're feeling and doing. **Choose UP TO THREE** potential goals for yourself over the next year. By rating your Confidence, Support, Motivation, and Ability to Learn for up to 3 goals, your Health Action Guide will lead you through the next steps toward accomplishing your top-rated goal.

Rate your Confidence, Support, Motivation, and Ability to Learn by the scale below.

0 = None or Not at all, 1 = A little, 2 = A fair amount, and 3 = A great amount.

5th step: Rate Your Ability to Learn: How would you rate your ability to learn new skills and behaviors for each goal chosen?

4th step: Rate Your Motivation: How motivated are you to start working on each goal chosen?

3rd step: Rate Your Support: What level of support do you think you will have for each goal chosen?

2nd step: Rate Your Confidence: How confident are you that you can be successful in changing each goal chosen?

1st step: Mark your goals: Mark **UP TO 3** goals from the list below & complete steps 2-5 for each goal chosen.

Confidence

Support

Motivation

Ability to Learn

GOALS TO IMPROVE PHYSICAL HEALTH

- Start, improve, or continue my exercise program
- Improve my nutritional habits primarily to feel better
- Improve my nutritional habits primarily to lose weight
- Drink 6-8 glasses of water a day
- Stop smoking or other tobacco use
- Stop overuse of alcohol
- Stop recreational drug use
- Get 7-8 hours of sleep most days
- Get regular doctor, dental, and vision checkups
- Watch my body for the 7 warning signs of cancer
- Seek help for a troubling physical symptom
- Better manage my chronic condition(s)
- Communicate better with my doctor
- Create safe living area
- Always wear seat belts whenever in a motor vehicle

GOALS TO IMPROVE EMOTIONAL HEALTH

- Learn how to better manage stress
- Learn how to better manage a particular stress emotion such as anxiety, fear, guilt, frustration, or anger
- Learn how to manage and/or seek help for depression

GOALS TO IMPROVE SOCIAL HEALTH

- Improve an important family relationship
- Improve communication skills
- Improve friend relationships
- Develop relationships I can count on for help and support
- Increase leisure activities

GOALS TO IMPROVE SPIRITUAL HEALTH

- Develop or deepen my spiritual beliefs
- Increase time for meditation and/or prayer
- Develop my sense of purpose/meaning in life
- Work on life planning
- Volunteer or increase charitable giving and/or work

GOALS TO IMPROVE INTELLECTUAL HEALTH

- Work on career planning
- Start or complete an educational goal
- Start or complete a skill training goal

