

Lifestyle Medicine

Short Assessment Form



These questions will ask you about your outlook and readiness to change, what is most important to you as far as your health goals, and your own health habits. There are no right or wrong answers. Please answer as honestly as you can.

Readiness to Change

On a scale of 0-10, with 0 being least and 10 being most, how important is it that you make lifestyle changes to improve your health?

0 1 2 3 4 5 6 7 8 9 10
Not Ready Somewhat Ready Very Ready

On a scale of 0-10, with 0 being least and 10 being most, how confident are you to make lifestyle changes to improve your health?

0 1 2 3 4 5 6 7 8 9 10
Not Confident Somewhat Confident Very Confident

Motivation

Please rank the top 3 areas you are most motivated to change in order to improve your current overall LEVEL OF HEALTH (1 being most motivated).

- Avoidance of Risky Substances
- Sleep
- Nutrition
- Social Connectedness
- Physical Activity
- Stress Management

Physical Activity: Exercise Vital Sign¹

For an average week in the last 30 days, how many days per week did you engage in moderate to vigorous exercise (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?

_____ days

On those days that you engage in moderate to vigorous exercise, how many minutes, on average, do you exercise?

_____ minutes

During the past month, how many times per week did you do physical activities or exercises to strengthen your muscles?

_____ times per week



Instructions

This brief questionnaire will ask about your **usual diet over the last 4 weeks**. Please try to answer as accurately as possible – there are no right or wrong answers. Your best guess is better than leaving a blank.

Please consider what you have typically eaten over the last 4 weeks when answering the following questions.

It's ok if something that you eat falls into more than one category.

Over the last four weeks, how often did you eat or drink the following items?



Fruit
(Apples, bananas, oranges, melon, berries, or any other fruit)

- | | |
|---|---|
| <input type="radio"/> Never | <input type="radio"/> 4-6 times a week |
| <input type="radio"/> Less than once a week | <input type="radio"/> 1-2 times a day |
| <input type="radio"/> 1-3 times a week | <input type="radio"/> 3 or more times a day |



Vegetables
(Cooked and raw leafy greens, broccoli, carrots, potatoes, peas, or any other vegetable or dishes that are mostly made from vegetables)

- | | |
|---|---|
| <input type="radio"/> Never | <input type="radio"/> 4-6 times a week |
| <input type="radio"/> Less than once a week | <input type="radio"/> 1-2 times a day |
| <input type="radio"/> 1-3 times a week | <input type="radio"/> 3 or more times a day |



Whole Grains or Whole Grain Products
(Oats, brown rice, whole grain bread or cereal, whole grain flour, or any other 100% whole grain products)

- | | |
|---|---|
| <input type="radio"/> Never | <input type="radio"/> 4-6 times a week |
| <input type="radio"/> Less than once a week | <input type="radio"/> 1-2 times a day |
| <input type="radio"/> 1-3 times a week | <input type="radio"/> 3 or more times a day |



White Bread, White Pasta, White Rice, or Foods Made from White Flour
(Any items made from white flour or white rice, like bread, tortillas, baked goods or snacks, pasta, or other foods)

- | | |
|---|---|
| <input type="radio"/> Never | <input type="radio"/> 4-6 times a week |
| <input type="radio"/> Less than once a week | <input type="radio"/> 1-2 times a day |
| <input type="radio"/> 1-3 times a week | <input type="radio"/> 3 or more times a day |



Packaged/Prepared, Restaurant, Takeout, or Fast Food Meals
(Any store-bought dishes or meals, refrigerated or frozen, or any kind of ready-to-eat meals or dishes, take-out, or meals from a restaurant)

- | | |
|---|---|
| <input type="radio"/> Never | <input type="radio"/> 4-6 times a week |
| <input type="radio"/> Less than once a week | <input type="radio"/> 1-2 times a day |
| <input type="radio"/> 1-3 times a week | <input type="radio"/> 3 or more times a day |



Sugary Foods and Beverages
(Sweetened (sugar added) breakfast cereals, sweetened yogurts, candy, other desserts, or other foods with added sugar, or any sweetened beverages including soda/pop, sweetened tea or coffee drinks, energy drinks, etc.)

- | | |
|---|---|
| <input type="radio"/> Never | <input type="radio"/> 4-6 times a week |
| <input type="radio"/> Less than once a week | <input type="radio"/> 1-2 times a day |
| <input type="radio"/> 1-3 times a week | <input type="radio"/> 3 or more times a day |

Nutrition: ACLM Diet Screener 9



Salty Foods

(Chips, crackers, or other salty snacks; canned soups, sauces, salad dressings, **or other foods with added salt**)

- Never
- 4-6 times a week
- Less than once a week
- 1-2 times a day
- 1-3 times a week
- 3 or more times a day



Fried Foods

(Fried foods such as French fries, onion rings, fried chicken or other meat, fried potatoes, fry bread, tempura, or **other fried foods**)

- Never
- 4-6 times a week
- Less than once a week
- 1-2 times a day
- 1-3 times a week
- 3 or more times a day

Which sources of protein did you eat frequently (2-3 times a week or more)?
Please select all that apply.

	<input type="radio"/> Beef, pork, or lamb		<input type="radio"/> Beans, peas or lentils, or products made from them
	<input type="radio"/> Lunchmeat, bacon, hot dogs, or sausage		<input type="radio"/> Nuts, seeds, or avocado
	<input type="radio"/> Poultry or poultry-based dishes		<input type="radio"/> Dairy and dairy products
	<input type="radio"/> Wild game (venison, elk)		<input type="radio"/> Eggs or egg-based dishes
	<input type="radio"/> Fish, shellfish, or seafood-based dishes		

Sleep

Over the last 2 weeks, **how many hours of sleep did you average in a 24-hour period?**

- Less than 4 hours
- 7-8 hours
- 4-5 hours
- 8-9 hours
- 5-6 hours
- 9 or more hours
- 6-7 hours

Over the last 2 weeks, **how often did you feel tired or have difficulty staying awake during routine tasks in the day?**

- Not at all
- More than half the days
- Several days
- Nearly every day

Mood - PHQ-2² (if not already present in electronic health record)

Over the last 2 weeks, how often have you been bothered by the following problems?

- | | | |
|--|------------------------------------|---|
| Little interest or pleasure in doing things | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several days | <input type="radio"/> Nearly every day |
| Feeling down, depressed, or hopeless | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several days | <input type="radio"/> Nearly every day |

*Note that a recent study was done on accuracy of using the PHQ-2 for detecting depression and frequency of completing the survey. We recommend users consider the findings when determining how to screen for depression in primary care settings.³

Meaning and Connectedness

- | | | |
|--|------------------------------------|---|
| Over the last 2 weeks, how often have you felt like your life had purpose or meaning? | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several days | <input type="radio"/> Nearly every day |

- | | | |
|--|------------------------------------|---|
| Over the last 2 weeks, how often have you felt connected with any support network (e.g. community, spiritual, friends/family, nature, yoga, or meditation)? | <input type="radio"/> Not at all | <input type="radio"/> More than half the days |
| | <input type="radio"/> Several days | <input type="radio"/> Nearly every day |

Stress - PSS-4³

These questions will ask you about your feelings and thoughts **during the last month**. In each case, please answer representing how often you felt or thought a certain way. Remember that there are no right or wrong answers, but it is most helpful if you can answer honestly and accurately. **Please think about the last 4 weeks** while you answer these questions.

- | | | |
|---|------------------------------------|----------------------------------|
| In the last month, how often have you felt that you were unable to control the important things in your life? | <input type="radio"/> Never | <input type="radio"/> Often |
| | <input type="radio"/> Almost never | <input type="radio"/> Very often |
| | <input type="radio"/> Sometimes | |

- | | | |
|---|------------------------------------|----------------------------------|
| In the last month, how often have you felt confident about your ability to handle your personal problems? | <input type="radio"/> Never | <input type="radio"/> Often |
| | <input type="radio"/> Almost never | <input type="radio"/> Very often |
| | <input type="radio"/> Sometimes | |

- | | | |
|---|------------------------------------|----------------------------------|
| In the last month, how often have you felt that things were going your way? | <input type="radio"/> Never | <input type="radio"/> Often |
| | <input type="radio"/> Almost never | <input type="radio"/> Very often |
| | <input type="radio"/> Sometimes | |

- | | | |
|--|------------------------------------|----------------------------------|
| In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? | <input type="radio"/> Never | <input type="radio"/> Often |
| | <input type="radio"/> Almost never | <input type="radio"/> Very often |
| | <input type="radio"/> Sometimes | |

Substance Use

In the case that a tool in the electronic medical record already exists to assess for the following substances, we recommend you use those assessment tools.

These questions will ask you about your use of tobacco, alcohol, and other substances. Remember that there are no right or wrong answers, but it is most helpful if you can answer honestly and accurately. **Please think about the last 4 weeks while you answer these questions.**

In the past 4 weeks, **how often have you used tobacco or any other nicotine product**, including e-cigarette, vaping, snuff, chewing tobacco, chew, plug, or twist?

Daily or almost daily Less than once a week
 Weekly Not at all

In the past 4 weeks, **how often in one day have you had 5 or more alcoholic drinks** (if you are a man) **or 4 or more drinks** (if you are a woman)?

Daily or almost daily Less than once a week
 Weekly Not at all

In the past 4 weeks, **how often have you used any prescription medications** just for the feeling, either more than prescribed or that were not prescribed for you?

Daily or almost daily Less than once a week
 Weekly Not at all

In the past 4 weeks, **how often have you used marijuana/cannabis** or any products made from it?

Daily or almost daily Less than once a week
 Weekly Not at all

In the past 4 weeks, **how often have you used any drugs** including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA, or any other similar substances?

Daily or almost daily Less than once a week
 Weekly Not at all

References:

1. HL7 FHIR® R4. Implementation Guide: Physical Activity, 1.0.0 -STU Release 1 In: Patient Care Work Group, Physical Activity Project Group, editors. 2023.
2. Gilbody, S., Richards, D., Brealey, S., & Hewitt, C. (2007). Screening for depression in medical settings with the Patient Health Questionnaire (PHQ): A diagnostic meta-analysis. *Journal of General Internal Medicine*, 22(11), 1596-1602. 10.1007/s11606-007-0333-y
3. Cohen S, Kamarck T, Mermelstein R. A global measure of perceived stress. *Journal of health and social behavior*. 1983;24(4):385-396.
4. Simon J, Panzer J, Wright KM, et al. Reduced accuracy of intake screening questionnaires tied to Quality Metrics. *Annals of Family Medicine*. September 1, 2023. Accessed September 19, 2024. <https://www.annfam.org/content/21/5/444>.