

Personal Health Risk Assessment Form

An initial tool for assessing your general health

	# of points		
I eat breakfast :		I consume fast food:	
Every day	0 pts	Never	0 pts
Most days	1 pt	Occasionally	1 pt
Rarely	2 pts	Weekly	2 pts
Never	3 pts	More than one time per week	3 pts
I eat ____ meals per day:		I consume soft drinks:	
5-6	0 pts	Never	0 pts
4	1 pt	Occasionally	1 pt
2-3	2 pts	Weekly	2 pts
1	3 pts	More than once per week	3 pts
I eat ____ servings of fruit per day:		I consume organic animal foods and wild fish:	
3-4	0 pts	Always	0 pts
2	1 pt	Sometimes	1 pt
1	2 pts	Never	2 pts
None	3 pts		
		I consume dairy products:	
I eat ____ servings of vegetables per day:		Never	0 pts
8-9	0 pts	Weekly	1 pt
6-7	1 pt	Daily	2 pts
5	2 pts	More than once per day	3 pts
Less than 5	3 pts		
		I drink 64 ounces of water:	
I eat ____ servings of whole grains per day:		Daily	0 pts
3 or more	0 pts	Most days	1 pt
2	1 pt	Rarely	2 pts
1	2 pts	Almost never	3 pts
Less than 1	3 pts		
		I drink alcohol:	
I eat foods containing ingredients like refined sugar, enriched flour and other negative ingredients:		1 time per week or less	0 pts
Almost never	0 pts	2 times per week	1pt
1-2 times per week	1 pt	3 times per week	2pts
3-4 times per week	2 pts	4 or more times per week	3pts
More than 4 times per week	3 pts		
		I consume oils (in salad dressing, cooking oils, in packaged foods):	
I consume artificial sweeteners:		Almost never	0 pts
Never	0 pts	Several times per week	1 pt
Occasionally	1 pt	Once per day	2 pts
Weekly	2 pts	More than once per day	3 pts
More than one time per week	3 pts		
		I drink coffee:	
		Occasionally	0 pts
		Weekly	1 pt
		Daily	2 pts
		More than one cup per day	3 pts

Smoking:

I have never smoked	0 pts
I quite over 5 years ago	0 pts
I quit less than 5 years ago	1 pts
I quit less than one year ago	2 pts
I currently smoke	5 pts

Sleep Habits:

I regularly go to bed between 10:00 and 11:00PM	0 pts
I go to bed after 11:00PM	2 pts
I go to bed after 12:00AM	3 pts

Stress:

Please check off those issues that are currently causing you stress:

<input type="checkbox"/> Children	<input type="checkbox"/> Divorce/Separation
<input type="checkbox"/> Parents	<input type="checkbox"/> Moving
<input type="checkbox"/> Spouse/significant other	<input type="checkbox"/> Not looking the way you want
<input type="checkbox"/> Work circumstances	<input type="checkbox"/> Lack of exercise
<input type="checkbox"/> Co-worker	<input type="checkbox"/> Financial
<input type="checkbox"/> Traffic	<input type="checkbox"/> Not enough hours in the day
<input type="checkbox"/> Lack of sleep	<input type="checkbox"/> Can't say "no"
<input type="checkbox"/> Physical illness	<input type="checkbox"/> Other
<input type="checkbox"/> Unfulfilled expectations	
<input type="checkbox"/> No time to yourself	

* Assign one point for each item you checked above*

Relationships:

I engage in social activities:

At least once per week	0 pts
Fewer than once per week	1 pt
Once per month	2 pts
Rarely	3 pts

Marriage/significant other:

I am happy being single/married/in a committed relationship	0 pts
I am unhappy being single/married/in a committed relationship	2 pts

Friends:

I have supportive friends	0 pts
My friends could be more supportive	1pt
My friends are not supportive	2pts
I need to make new friends	3pts

Job/Career:

I like my job	0 pts
I like only parts of my job	1pt
I wish I had a different job	2pts
I wish I had a different career	3pts

Personal:

I like myself	0 pts
I like some aspects of myself	1pt
I need to make major improvements in myself	2pts
I don't like myself	3pts

Outlook:

I am very optimistic	0 pts
I am usually optimistic	1pt
I often feel pessimistic	2pts
I tend to be pessimistic	3pts

Exercise:

Number of days you work out:

5 or more days/week	0 pts
4-2 days/week	1pt
Maybe 1/week	2pts
Never	3pts

Length of each workout

45 minutes or longer	0 pts
30-40 minutes	1pt
20-30 minutes	2pts
Less than 20 minutes	3pts

I do weight training:

2 or more times per week	0 pts
1 time per week	1pt
A couple times per month	2pts
Rarely	3pts

PART I SUBTOTAL _____

Assign 3 points for every item checked below:

- _____ Do you often wake up feeling tired?
- _____ Do you regularly experience fatigue during the day?
- _____ Do you suffer from frequent headaches or migraines?
- _____ Are you more than 10 pounds overweight?
- _____ Does your weight fluctuate often?
- _____ Do you experience lack of mental clarity or memory loss?
- _____ Do you have problems with digestion?
- _____ Do you have asthma?
- _____ Do you have allergies?
- _____ Do you frequently get colds, sinus congestion or flu-like symptoms?
- _____ Do you experience bouts of depression or anxiety?
- _____ Do you have arthritis?
- _____ Do you suffer from any autoimmune disorders?
- _____ Do your joints hurt?
- _____ Do you have trouble going to sleep or sleeping through the nights?
- _____ Do you frequently experience food cravings?
- _____ Do you frequently eat when you are not hungry?
- _____ Do you often feel stressed out?
- _____ Do you ever feel bloated or uncomfortable after eating?
- _____ Are you regularly taking over the counter medications?
- _____ Do you take pharmaceutical drugs?

PART II SUBTOTAL _____

PARTS I & II TOTAL _____

Scoring System:

under 20 points

You are doing a great job. Of course it would be best if you scored no points, but no one is perfect! Keep working at maintaining dietary excellence and optimal habits.

21-35 points

Although you are doing a lot of the right things, your risk of developing degenerative diseases is elevated and there is room for improvement

36-50 points

Your diet at lifestyle are in need of improvement in order to reduce your risk of diseases like cardiovascular disease, cancer, and diabetes. Best to start now!

51-65 points

Immediate changes are needed, as your risk is quite high.

66 or higher

You are in the highest risk category for developing conditions associated with poor diet and lifestyle