Draft

PERSONAL HEALTH ASSESSMENT

This Personal Health Assessment (PHA) is designed to give you information about your health and help guide you in your efforts toward making healthy behavior changes. All of the information you provide on this survey will be kept strictly confidential and will only be used to provide you with information about your health risk factors and to invite you to join wellness programs. Our goal is to provide you with tools and information you can use to make healthy lifestyle changes.

Learn more about your health. It only takes about 20 minutes to complete this assessment. The information and tools provided to you once completed, however, may help improve your health and quality of life for many years to come.

If you have any questions about this PHA, please call: 1-877-252-8412.

Healthways Consent Form

I consent to participate in this wellness program (the "Program"), which involves completing an on-line or written Personal Health Assessment (PHA). I understand that my participation in the Program is voluntary and that I am not required to participate as a condition of employment or of enrollment in my health plan.

In addition, I consent to being provided with a report (either on-line or in writing) of my PHA results and, if applicable, periodically providing me with follow-up educational materials and information relevant to my PHA results.

I understand that the Program is offered by my health plan or employer acting as the sponsor of my health plan. If my health plan implements an incentive program as part of the Program, I consent to Healthways informing my health plan or my employer acting as the sponsor of my health plan whether or not I qualify for such incentive based upon my participation in the Program. I understand that if I do not elect to provide such consent, I may not qualify for such incentive.

I understand that my health plan or employer acting as the sponsor of my health plan may from time to time offer enrollees other health and wellness services and programs (collectively, "Other Health/Wellness Programs"), such as employee assistance and disease management programs. By my signature below, I consent to the disclosure by Healthways of my PHA results and/or other personal health information that identifies me to Other Health/Wellness Program providers, so that they may contact me for the purpose of addressing my particular health/wellness needs. I understand that Healthways and/or my health plan or employer acting as the sponsor of my health plan will require such Other Health/Wellness Program providers to agree to maintain the confidentiality of any PHA results and/or other personal health information provided to them by Healthways. I understand that if I do not want Healthways to disclose my PHA results and/or other personal health information to Other Health/Wellness Program providers, I must notify Healthways in writing.

I understand that this consent will remain in effect for as long as I participate in the Program or such shorter period permitted by law. I may revoke this consent at any time by notifying Healthways in writing, to the extent Healthways has not already relied on this consent.

Any notice to Healthways should be sent to Wellmark Blue Cross and Blue Shield, P.O. Box 983, Des Moines, Iowa 50304-0983, Attn: MHIQ. I understand that I am entitled to a copy of this consent.

M M / D D / Y Y Y Y

Name: PLEASE PRINT **Signature:** PLEASE SIGN **Date of Signature:**

Form Version: 2 0 6 . 1

Draft

INSTRUCTIONS:

Use a pencil, black or blue pen. Fill response bubbles completely. Do **not** use X's or √'s to indicate your responses. Do **not** use red ink.

Correct Mark

Incorrect Marks

Example

1 2

Receive Your Report Online

Yes, Online Report

The quickest way to receive your personal health report is online. Provide your email address to receive instant notification when your report is ready.

@

EMAIL ADDRESS

FORMAL NAME & ADDRESS

FIRST NAME

MIDDLE INITIAL or MIDDLE NAME

LAST NAME

STREET ADDRESS

APARTMENT OR SUITE#

CITY

STATE

ZIP

DEMOGRAPHICS

Gender

Male   Female

Date of Birth   M M / D D / Y Y Y Y

What is your daytime telephone number?   - -

Extension

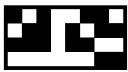
You are:

- White
- Black
- Hispanic
- Asian
- Pacific Islander
- American Indian
- Other

Health Assessment Activation Code

Fill in both boxes and bubbles

1
2
3
4
5
6
7
8
9
0


Draft

SELF AWARENESS

16. Do you know what your total cholesterol number was the last time you had it tested?
○ Yes, I know. ○ No, I don't know. ○ I've never had it tested.

16a. If yes, what was your total cholesterol number the last time it was tested? ☐☐☐

17. Do you know what your LDL (bad) cholesterol number was the last time you had it tested?
○ Yes, I know. ○ No, I don't know. ○ I've never had it tested.

17a. If yes, what was your LDL number the last time it was tested? ☐☐☐

18. Do you know what your HDL (good) cholesterol was the last time you had it tested?
○ Yes, I know. ○ No, I don't know. ○ I've never had it tested.

18a. If yes, what was your HDL number the last time it was tested? ☐☐☐

19. Do you know what your triglycerides number was the last time you had it tested?
○ Yes, I know. ○ No, I don't know. ○ I've never had it tested.

19a. If yes, what was your triglycerides number the last time it was tested? ☐☐☐

20. Do you know what your glucose number was the last time you had it tested?
○ Yes, I know. ○ No, I don't know. ○ I've never had it tested.

20a. Was the glucose number: ○ Fasting **(go to question #20b)**
○ Non-Fasting **(go to question #20c)**

20b. If yes, what was your fasting glucose number the last time it was tested? ☐☐☐

20c. If yes, what was your non-fasting glucose number the last time you had it tested? ☐☐☐

21. Do you know what your blood pressure was the last time you had it checked?
○ Yes, I know. ○ No, I don't know. ○ I've never had it tested.

21a. If yes, what was your systolic (upper number) blood pressure the last time you had it checked? ☐☐☐

21b. If yes, what was your diastolic (lower number) blood pressure the last time you had it checked? ☐☐☐

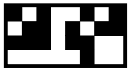
MEDICAL HISTORY

22. How tall are you?
☐ ft. ☐☐ in.

23. How much do you weigh (in pounds)?
☐☐☐

24. Has a doctor told you that you have any of the following? **(fill in ● all that apply)**

○ Allergies
○ Angina (chest pain)
○ Asthma. . . . . **(if Yes, also answer #24a)**
○ Back pain
○ Cancer. . . . . . . **(if Yes, also answer #24g)**
○ Chronic bronchitis, emphysema or COPD (lung problems)
○ Congestive heart failure (heart pump problems)
○ Coronary artery disease. . . . . . . **(if Yes, also answer #24b)** (heart problems or hardening of arteries)
○ Depression. . . **(if Yes, also answer #24c)**
○ Diabetes. . . . . **(if Yes, also answer #24d)**
○ End stage renal disease
○ Frequent colds (3 or more a year)
○ High cholesterol (fat in the blood)
○ Hypertension. .**(if Yes, also answer #24e)** (high blood pressure)
○ Kidney disease
○ Liver disease
○ Migraines. . **(if Yes, also answer #24f)**
○ Osteoporosis (weak bones)
○ Past stroke
○ Prostate problems
○ Thyroid problems
○ Do not know
○ None of these



Draft

MEDICAL HISTORY (Continued)

24a. My **asthma** is being treated successfully as recommended by my doctor.	○ Yes	○ No
24b. My **coronary artery disease** is being treated successfully as recommended by my doctor.	○ Yes	○ No
24c. My **depression** is being treated successfully as recommended by my doctor.	○ Yes	○ No
24d. My **diabetes** is being treated successfully as recommended by my doctor.	○ Yes	○ No
24e. My **hypertension** is being treated successfully as recommended by my doctor.	○ Yes	○ No
24f. My **migraines** are being treated successfully as recommended by my doctor.	○ Yes	○ No
24g. Are you currently being treated for **cancer** or any **cancer-related** complications?	○ Yes	○ No

Answer this question ONLY if you answered that a doctor has told you that you have High Cholesterol

Consistently taking your cholesterol medication means: taking the entire dose you and your doctor agreed was right for you without forgetting, missing, skipping, or adjusting your dose; and contacting your doctor if you have questions, concerns, or are unsure about if you need to stay on the medication.

25. Do you consistently take cholesterol medication according to the previous definition?

- ○ No, and I do not intend to in the next 6 months
- ○ No, but I intend to in the next 6 months
- ○ No, but I intend to in the next 30 days
- ○ Yes, I have been but for less than 6 months
- ○ Yes, I have been for 6 months to a year
- ○ Yes, I have been for more than 1 year
- ○ I have not been given a prescription for cholesterol-lowering medication

Answer this question ONLY if you answered that a doctor has told you that you have Hypertension

Consistently taking your blood pressure medication means: taking the entire dose you and your doctor agreed was right for you without forgetting, missing, skipping, or adjusting your dose; and contacting your doctor if you have questions, concerns, or are unsure about if you need to stay on the medication.

26. Do you consistently take blood pressure medication according to the previous definition?

- ○ No, and I do not intend to in the next 6 months
- ○ No, but I intend to in the next 6 months
- ○ No, but I intend to in the next 30 days
- ○ Yes, I have been but for less than 6 months
- ○ Yes, I have been for 6 months to a year
- ○ Yes, I have been for more than 1 year
- ○ I have not been given a prescription for high blood pressure medication

27. In the past 12 months, how many times have you:

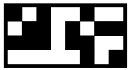
a. Gone to the emergency room?	○ 0 times	○ 1-2 times	○ 3-5 times	○ 6 or more times
b. Stayed overnight in a hospital?	○ 0 times	○ 1-2 times	○ 3-5 times	○ 6 or more times

28. Are you thinking about any of the following in the near future? **(fill in ● all that apply)**

- ○ Joint replacement
- ○ Hysterectomy
- ○ Back surgery
- ○ Heart surgery
- ○ Prostate surgery
- ○ Other surgery
- ○ None of these

29. Do you have a family history (brother, sister, mother, father, grandparents) of: **(fill in ● all that apply)**

- ○ Diabetes
- ○ High Blood Pressure
- ○ Stroke
- ○ Cancer
- ○ Heart Problems
- ○ High Cholesterol
- ○ Kidney Disease
- ○ None



Draft

PREVENTIVE HEALTH SERVICES

30. When was the last time you had a flu shot?

- Within the past 12 months
- More than 12 months ago
- Not sure
- Never had a flu shot

31. Have you been checked for colon cancer by a doctor (through stool test, blood test, scope, etc)?

- Yes
- No
- Not applicable because I am 49 years of age or younger

32. Have you seen a dentist in the past 12 months? ○ Yes ○ No

WOMEN'S HEALTH (For Women Only)

33. Are you pregnant?

- Yes **(if Yes, go to question #33a)**
- No **(if No, go to question #34)**

Answer questions 33a and 33b ONLY if you are pregnant

33a. How many months have you been pregnant?

- 1 to 3 months
- 4 to 6 months
- 7 to 9 months
- Not sure

33b. Are you under a doctor's care for your pregnancy?

- Yes
- No

34. Have you ever had a breast x-ray? (mammogram)

- Yes
- No
- Not applicable because I am 39 years of age or younger

35. How long has it been since you had your last Pap smear? (A Pap Smear is a test for cancer of the cervix.)

- Within the past 1 year
- Within the past 3 years
- 4 or more years ago
- I have never had a pap smear

EMOTIONAL HEALTH

Stress management includes regular relaxation, physical activity, talking with others, and/or making time for social activities.

36. Do you effectively practice stress management in your daily life?

- No, and I do not intend to in the next 6 months
- No, but I intend to in the next 6 months
- No, but I intend to in the next 30 days
- Yes, I have been, but for less than 6 months
- Yes, I have been for more than 6 months
- I currently do not have any stress in my life

37. In general, how satisfied are you with your life?

- Completely satisfied
- Mostly satisfied
- Partly satisfied
- Not satisfied

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

a. Little interest or pleasure in doing things	○ Not at all	○ Several days	○ More than half the days	○ Nearly every day
b. Feeling down, depressed, or hopeless	○ Not at all	○ Several days	○ More than half the days	○ Nearly every day

39. During the past 12 months, how many days did your feelings keep you from working all or most of the day?

○ None ○ 1 - 2 days ○ 3 - 5 days ○ 6 or more days

40. How often do you use drugs or medications (including prescriptions) which affect your mood or help you relax?

○ Almost every day ○ Sometimes ○ Rarely or never

Draft

PHYSICAL HEALTH

41. During the past 12 months, how many days did being sick or injured keep you from working all or most of the day?

- ○ None
- ○ 1 - 2 days
- ○ 3 - 5 days
- ○ 6 or more days

42. Compared to others your age, how would you describe your overall health?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

WEIGHT MANAGEMENT

Healthy eating means doing both of the following:

- Eating the number of calories that allows you to reach and maintain a healthy weight
- Eating a diet that is low in fat

Eating the number of calories that allows you to reach and maintain a healthy weight means doing things like:

- Paying attention to serving sizes
- Telling yourself that every calorie counts
- Eating small portions
- Eating more vegetables and fruits
- Avoiding taking handfuls of unhealthy snacks

43. Do you eat the number of calories that allows you to reach and maintain a healthy weight? ○ Yes ○ No

Eating a low-fat diet means doing things like:

- Eating fruits and vegetables as snacks
- Eating chicken without the skin
- Eating bread without butter
- Eating low-fat cheeses and other low-fat dairy products
- Using light or fat-free salad dressing, or eating salad without dressing

44. Do you eat a diet that is low in fat? ○ Yes ○ No

Answer this question ONLY if you answered "No" to either 43 or 44

45. Are you planning to change what you eat so you can answer YES to the two previous questions?

- ○ NO, and I do NOT intend to in the next 6 months
- ○ YES, and I intend to in the next 6 months
- ○ YES, and I intend to in the next 30 days

Answer this question ONLY if you answered "Yes" to BOTH 43 & 44

46. How long have you been doing these two things?

- ○ For LESS than 6 months
- ○ For MORE than 6 months

EXERCISE HABITS

Regular moderate exercise is any planned physical activity (e.g., fast walking, aerobics, jogging, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, dancing, etc.) performed to increase physical fitness. Exercise should be done at a level that increases your breathing rate and causes you to break a light sweat.

47. Do you engage in regular moderate exercise according to the previous definition **5-7 times per week** for at least **30 minutes**?

- ○ No, and I do not intend to in the next 6 months
- ○ No, but I intend to in the next 6 months
- ○ No, but I intend to in the next 30 days
- ○ Yes, I have been, but for less than 6 months
- ○ Yes, I have been for more than 6 months

48. During the past month, other than your regular job, how often did you participate in any physical activity (exercise that was hard enough to make you breathe heavily and increase your heart rate and was done for at least 30 minutes)?

- ○ Less than 1 time per week
- ○ 1 - 2 times per week
- ○ 3 times per week
- ○ 4 times per week
- ○ 5 or more times per week

Draft

NICOTINE

49. Have you ever smoked tobacco products (cigarettes, cigars, pipes)?
   - ○ Yes **(if Yes, go to question #50)**
   - ○ No **(if No, go to question #51)**

50. Have you quit smoking tobacco products?
   - ○ No, and I do not intend to quit in the next 6 months
   - ○ No, but I intend to quit in the next 6 months
   - ○ No, but I intend to quit in the next 30 days
   - ○ Yes, I quit less than 6 months ago
   - ○ Yes, I quit more than 6 months ago

51. Do you use any of the following:
   - ○ Smokeless Tobacco
   - ○ Nicotine Replacement Therapy

52. Does anyone in your current household or immediate work environment smoke?
   - ○ Yes
   - ○ No

ALCOHOL AND SUBSTANCE USE

53. Do you drink alcohol?
   - ○ Yes **(if Yes, go to question #53a)**
   - ○ No **(if No, go to question #54)**

53a. If you answered "Yes", how many alcoholic drinks do you have in a typical week?
(one drink is equal to one beer, one glass of wine, one shot of liquor, or one mixed drink)
   - ○ Rarely
   - ○ 0-4 drinks a week
   - ○ 5-9 drinks a week
   - ○ 10-13 drinks a week
   - ○ 14 or more drinks a week

54. Do you use or experiment with drugs?
   - ○ Yes **(if Yes, go to question #55)**
   - ○ No **(if No, go to question #56)**

Answer this question ONLY if you answered "Yes" to either 53 & 54

55. During the last three months: **(fill in ● all that apply)**
   - ○ have you felt you should cut down or stop drinking or using drugs?
   - ○ has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
   - ○ have you felt guilty or bad about how much you drink or use drugs?
   - ○ have you woken up wanting to have an alcoholic drink or use drugs?
   - ○ This question does not apply to me.

WORK AND FAMILY

56. Are you satisfied with your job?
   - ○ Completely satisfied
   - ○ Mostly satisfied
   - ○ Partly satisfied
   - ○ Not satisfied

SAFETY

57. How often do you wear your seatbelt when driving or riding in a car or truck?
   - ○ 100%
   - ○ 90 - 99%
   - ○ Less than 90%

SAFE SEX

58. What percentage of the time do you practice safe sex?
   - ○ 100% of the time
   - ○ 90 - 99% of the time
   - ○ Less than 90% of the time
   - ○ I'm not sexually active

Draft

PRODUCTIVITY

59. In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following?

a. work the required number of hours?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

b. get going easily at the beginning of the workday?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

c. start on your job as soon as you arrived at work?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

d. do your work without stopping to take breaks or rests?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

e. stick to a routine or schedule?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

60. In the past 2 weeks, how much of the time were you ABLE TO DO the following without difficulty caused by physical health or emotional problems?

a. walk or move around different work locations (for example, go to meetings)?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

b. lift, carry, or move objects at work weighing more than 10 lbs?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

c. sit, stand, or stay in one position for longer than 15 minutes while working?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

d. repeat the same motions over and over again while working?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

e. bend, twist, or reach while working?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

f. use hand-held tools or equipment (for example, a phone, pen, keyboard, computer mouse, drill, hairdryer, or sander)?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

61. In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following?

a. keep your mind on your work?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

b. think clearly when working?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

c. do work carefully?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

d. concentrate on your work
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

e. work without losing your train of thought?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

f. easily read or use your eyes when working?
- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

Draft

PRODUCTIVITY (Continued)

62. In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following?

a. speak with people in-person, in meetings or on the phone?

- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

b. control your temper around people when working?

- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

c. help other people to get work done?

- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

63. In the past 2 weeks, how much of the time did your physical health or emotional problems make it difficult for you to do the following?

a. handle the workload

- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

b. work fast enough?

- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

c. finish work on time?

- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

d. do your work without making mistakes?

- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

e. feel you've done what you are capable of doing?

- ○ All of the time (100%)
- ○ Most of the time
- ○ Some of the time (about 50%)
- ○ A slight bit of the time
- ○ None of the time (0%)
- ○ Does not apply to my job

MISCELLANEOUS

Being an Effective Healthcare Consumer means doing the following: using the Emergency Room wisely, possessing a clear understanding of your healthcare benefits, using a self-care manual, working with your doctor to ensure that proper preventative exams are taken at the appropriate time, etc.

64. I know how to be an effective healthcare consumer.

○ Strongly Disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly Agree

65. I have access to resources, tools and services my family and I need to make good health care decisions.

○ Strongly Disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly Agree

66. I have a health care provider who knows me and my health history.

○ Yes ○ No

67. I understand what services my health plan covers.

○ Strongly Disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly Agree

Draft

MISCELLANEOUS (Continued)

68. I believe that I, and or my family, can affect health care costs by:

A. How I / we use health care services

○ Strongly Disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly Agree

B. How I / we take care of our health

○ Strongly Disagree ○ Disagree ○ Neither agree nor disagree ○ Agree ○ Strongly Agree

69. I have computer access to the internet:

○ At home ○ At work ○ Both

70. If you participated in a health program, how would you prefer to learn/receive information? **(fill in ● all that apply)**

○ Audiotapes/CD's
○ Print Materials (books, newsletter, brochures
○ Self-paced, computer-based health programs
○ Multi-session, instructor led courses
○ Single session group workshops/seminars
○ One-on-one telephone support with a health professional
○ One-on-one in-person support with a health professional
○ Support groups in-person
○ Support groups - online chat sessions
○ Professional advice via email by a health professional (i.e., dietician, exercise specialist, nurse, counselor)
○ Community sponsored classes/group activities

71. What would be the most-preferred method listed to motivate you to make lifestyle changes to improve your health?

○ Personal well-being/better quality of life
○ Advice from Doctor/Health Care Provider
○ Cash
○ Incentive gifts (T-shirts, travel vouchers, gift cards, etc)
○ Paid time off
○ Health improvement Competition
○ Personal Recognition
○ Other

72. What would be the second most-preferred method listed to motivate you to make lifestyle changes to improve your health?

○ Personal well-being/better quality of life
○ Advice from Doctor/Health Care Provider
○ Cash
○ Incentive gifts (T-shirts, travel vouchers, gift cards, etc)
○ Paid time off
○ Health improvement Competition
○ Personal Recognition
○ Other

73. What would be the third most-preferred method listed to motivate you to make lifestyle changes to improve your health?

○ Personal well-being/better quality of life
○ Advice from Doctor/Health Care Provider
○ Cash
○ Incentive gifts (T-shirts, travel vouchers, gift cards, etc)
○ Paid time off
○ Health improvement Competition
○ Personal Recognition
○ Other