Fort Campbell
AFWC
ARMED FORCES WELLNESS CENTER

Personal Information

First Name: _____ Last Name: _____

Date: _____ DOB: _____ Gender: ☐Male ☐Female

Social Security Number: _____ or DOD ID: _____

Military Branch: Select One

- ☐ Army
- ☐ Air Force
- ☐ Navy
- ☐ Marine Corp
- ☐ Coast Guard
- ☐ Space Force

Status: Select One

- ☐ Active Duty
- ☐ Reserve
- ☐ Guard
- ☐ Civilian
- ☐ Family Member
- ☐ Retiree
- ☐ Other: _____

Unit Name: _____

Unit (Specify your Unit Identification Code): _____

Rank (ex. SGT E-5): _____

Contact Information

Home Phone: Work _____ Cell Phone: _____

Phone: _____ Email: _____

Emergency Information

Emergency Contact: _____ Phone: _____

Contact Relationship: _____ Phone: _____

Primary Doctor: _____

Program Participation

Are you participating in the Army Body Composition Program? ◯ Yes ◯ No

Are you participating in the Weight Loss Initiative Program? ◯ Yes ◯ No

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Complete this Questionnaire EVERY 30 DAYS by paper or at https://awc.army.mil

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Referral Information *(for first-time visitors only)*

1. How did you ***learn*** about the Army Wellness Center?
   - ◯ Electric Media (e.g. website, social media, video, online advertisement)
   - ◯ Print Media (e.g. paper advertisement, flyer, brochure)
   - ◯ Briefing or Presentation (e.g. in-processing brief, orientation brief, presentation)
   - ◯ Health Fair
   - ◯ Word of Mouth
   - ◯ Other (specify):_____

2. If you selected **word of mouth**, specify from whom:
   - ◯ Friend
   - ◯ Family member
   - ◯ Coworker
   - ◯ Unit Commander, Leader, or Supervisor
   - ◯ Doctor/Physician
   - ◯ Nurse
   - ◯ Dietician
   - ◯ Physical Therapist
   - ◯ Behavioral Health Provider
   - ◯ Army Wellness Center Staff
   - ◯ Fitness Professional/Moral, Welfare, and Recreation (MWR)

3. How were you ***referred*** to the Army Wellness Center?
   - ◯ Not referred/self-referred
   - ◯ Friend
   - ◯ Family member
   - ◯ Coworker
   - ◯ Unit Commander, Leader, or Supervisor
   - ◯ Doctor/Physician
   - ◯ Nurse
   - ◯ Dietician
   - ◯ Physical Therapist
   - ◯ Behavioral Health Provider
   - ◯ Army Wellness Center Staff
   - ◯ Fitness Professional/Moral, Welfare, and Recreation (MWR)
   - ◯ Other (specify):_____

How were you referred to the Army Wellness Center?

_____

Visit Information

Do you have any allergies? ◯ Yes ◯ No Please list your allergies:_____

Are you in pain today? ◯ Yes ◯ No Please rate your pain: ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

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Health and Wellness Goals

Which of the following describe your health and wellness goals? (check all that apply):

- □ Aerobic Fitness
- □ General Fitness
- □ Reduce Stress
- □ Increase Flexibility
- □ Lose Body Fat
- □ Increase Strength
- □ Stop Smoking
- □ Gain Muscle
- □ Lower Blood Pressure
- □ Improve Cholesterol
- □ Lose Weight
- □ Maintain Weight
- □ Improve Diet and Nutrition
- □ Improve ACFT Performance
- □ Other: _____

What is your primary health and wellness goal? _____

Tobacco / Nicotine Habits

Describe your current tobacco use habits.

- ○ Never Smoked
- ○ Current Cigarette Smoker Current
- ○ Current Pipe Smoker
- ○ Current Smokeless Tobacco User
- ○ Current Cigar Smoker
- ○ Previous Cigarette Smoker
- ○ Previous Pipe Smoker
- ○ Previous Smokeless Tobacco User
- ○ Previous Cigar Smoker

If current cigarette smoker, how often do you smoke?
____ Cigarettes per: ○ Day ○ Week ○ Month ○ Year

If current smokeless tobacco user, how often do you use smokeless tobacco?
____ times per: ○ Day ○ Week ○ Month ○ Year

Alcohol Consumption

Do you consume alcohol? ○ Yes ○ No
How many alcoholic drinks do you consume during a typical day? _____
*One drink = 12 0z of beer, 5 oz wine, 1.5 ounces of 80 proof distilled spirits

How often do you drink five (four for women) or more alcoholic drinks on one occasion?
*One occasion = any event where drinking exceeds one drink per hour

○ Daily ○ Weekly ○ Monthly ○ Once or twice per year ○ Never

Safety

How often do you drive after drinking?

- ○ More than once in the past 6 months
- ○ Once during the past 6 months
- ○ At least once in the past year
- ○ Not once during the past year

How often do you use a seat belt when you drive or ride as a passenger in a car?

- ○ Always
- ○ Most of the time
- ○ Sometimes
- ○ Rarely
- ○ Never

How often do you wear a helmet when you ride a motorcycle, all-terrain vehicle, or bicycle?

- ○ Always
- ○ Most of the time
- ○ Sometimes
- ○ Rarely
- ○ Never
- ○ Does not apply to me

Dietary Habits

About how many cups of fruits and vegetables do you eat per day?

○ At least five ○ Four ○ Three ○ Two ○ One ○ Less than one

Indicate how often you eat the following:

	At most every meal	At least once a day	3-5 days a week	Less than 3 days a week	Rarely or never
High fiber foods	○	○	○	○	○
Low-fat foods	○	○	○	○	○
High sugar desserts	○	○	○	○	○
High fat desserts	○	○	○	○	○
Foods high in sodium	○	○	○	○	○

Notes: _____

Exercise Habits

Do you currently exercise? ○ Yes ○ No

1) On average how many **minutes per week** do you engage in moderate intensity aerobic activity (working hard enough to raise your heart rate and break a sweat, i.e. brisk walking, swimming leisurely, leisurely biking)? _____

2) On average, how many **minutes per week** do you engage in vigorous intensity aerobic activity (e.g., jogging/running, swimming laps, jumping rope)? _____

3) On average, how many **days per week** do you engage in muscle strengthening activities (legs, hips, back, abdomen, chest, shoulders, and arms)? ○1 ○2 ○3 ○4 ○5 ○6 ○7

Other

How many hours of sleep do you get per night? _____ hours

Army Combat Fitness Test (ACFT) Performance

***ONLY APPLICABLE FOR ACTIVE DUTY AND RESERVIST**

Please enter the information requested below about the MOST RECENT for record ACFT

Test Date: _____ **(MM/DD/YYYY; Please provide your best estimate if you do not know the exact date)**

Event 1: 3 Repetition Maximum Deadlift.
Did you complete this event?
○ Yes
○ No
Maximum Weight Lifted:_____ **(Raw Weight, NOT POINTS)**

Event 2: Standing Power Throw.
Did you complete this event?
○ Yes
○ No
Distance Thrown: _____ **(Distance Thrown in Meters '0.0', NOT POINTS)**

Event 3: Hand Release Push-Up
Did you complete this event?
○ Yes
○ No
Number of Push-Ups: _____ **(Number of Push-Ups, NOT POINTS)**

Event 4: Sprint-Drag-Carry (SDC)
Did you complete this event?
○ Yes
○ No
Event Time: _____ **(Time in MM:SS, NOT POINTS)**

Event 5: Plank (PLK)
Did you complete this event?
○ Yes
○ No
Event Time: _____ **(Time in MM:SS, NOT POINTS)**

Event 6: Select One
○ 2 Mile Run
○ 2.5 Mile Walk
○ 5K Row
○ 12K Stationary Bike
○ 1K Swim
Event Time: _____ **(Time in MM:SS, NOT POINTS)**

Did you pass ACFT?
○ Yes
○ No
○ Don't Know

What was the total number of points scored in this ACFT? _____ Don't Know: ○

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Are you stressed?

	Never	Almost Never	Some-times	Fairly Often	Very Often
In the last month, how often have you been upset because of something that happened unexpectedly?	○	○	○	○	○
In the last month, how often have you felt that you were unable to control the important things in your life?	○	○	○	○	○
In the last month, how often have you felt nervous and stressed?	○	○	○	○	○
In the last month, how often have you felt confident about your ability to handle your personal problems?	○	○	○	○	○
In the last month, how often have you felt that things were going your way?	○	○	○	○	○
In the last month, how often have you found that you could not cope with all the things you had to do?	○	○	○	○	○
In the last month, how often have you been able to control irritations in your life?	○	○	○	○	○
In the last month, how often have you felt that you were on top of things?	○	○	○	○	○
In the last month, how often have you been angered because of things that were outside of your control?	○	○	○	○	○
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	○	○	○	○	○

Are you confident that you can change?

The following questions ask you to indicate how confident and competent you feel to achieve a healthier lifestyle. Please indicate your agreement with each item on the following scale.
I feel confident and competent to:

	N/A	Almost Never True	Usually Not True	Some-times but Infre-quently True	Occa-sionally True	Often True	Usually True	Almost Always True
Improve my physical fitness	○	○	○	○	○	○	○	○
Improve my diet and nutrition habits	○	○	○	○	○	○	○	○
Improve my stress management skills	○	○	○	○	○	○	○	○
Quit or cut back on tobacco use	○	○	○	○	○	○	○	○
Improve my sleeping habits	○	○	○	○	○	○	○	○
Drink alcoholic beverages in moderation	○	○	○	○	○	○	○	○

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Are you ready to change?

	N/A	I won't do it	I can't do it	I may do it	I will do it	I am doing it	I am still doing it
Improve my physical fitness	○	○	○	○	○	○	○
Improve my diet and nutrition habits	○	○	○	○	○	○	○
Improve my stress management skills	○	○	○	○	○	○	○
Quit or cut back on tobacco use	○	○	○	○	○	○	○
Improve my sleeping habits	○	○	○	○	○	○	○
Drink alcoholic beverages in moderation	○	○	○	○	○	○	○

Pre-Participation Health Screening:

Have you participated in structured physical activity for at least 30 minutes at moderate intensity on at least 3 days of the week for the last 90 days? (The CDC states if you are doing moderate intensity activity you can talk, but not sing during the activity). ○ Yes ○ No

Did your father, brother or first degree male relative suffer from a heart attack before the age of 55 yrs old? ○ Yes ○ No

Did your mother, sister or first degree female relative suffer from a heart attack before age 65 yrs old? ○ Yes ○ No

Your BMI: Height: _____ feet _____ inches Weight: _____ lbs.

Have you been told you have high cholesterol?..... ○ Yes ○ No

Have you been told your "good" cholesterol is high?..... ○ Yes ○ No

Have you been told you are pre-diabetic?..... ○ Yes ○ No ○ Don't Know

Have you been told you have high blood pressure?..... ○ Yes ○ No ○ Don't Know

Do you currently have (or have had in the last 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? (Please answer NO if you had a problem in the past, but it does not limit your current physical activity)..... ○ Yes ○ No ○ Don't Know

Are you currently taking prescribed medication(s) for a chronic medical condition? ○ Yes ○ No

Known Personal Disease:

Do you have any personal history of cardiovascular, cardiac, peripheral vascular or cerebrovascular disease?..... ○ Yes ○ No

Do you have any personal history of metabolic disease, Type I or Type II diabetes, or renal disease?..... ○ Yes ○ No

Do you have any personal history of pulmonary disease, asthma, interstitial lung disease or cystic fibrosis?..... ○ Yes ○ No

Suggestive Personal Disease: *When you are at rest or physically active, do you experience:*

Pain or discomfort in chest, neck, jaw, arms, or other areas that may result from blood flow deficiency?..... ○ Yes ○ No

Shortness of breath at rest or with mild exertion?..... ○ Yes ○ No

Dizziness or fainting?..... ○ Yes ○ No

Difficulty breathing while lying down or sudden breathing problems at night?..... ○ Yes ○ No

Rapid throbbing or fluttering of the heart?..... ○ Yes ○ No

Severe cramping pain in leg muscles during walking?..... ○ Yes ○ No

Swelling of the ankles?..... ○ Yes ○ No

Known heart murmur?..... ○ Yes ○ No

Unusual fatigue or shortness of breath during usual activities?..... ○ Yes ○ No

Clear Form