



Congregational Health + Wellness Survey

We hope to have your participation in building a robust Health + Wellness Program at First Congregational Church of Murphys UCC by completing this survey. This will help us understand your needs and those of your family, as well as help us to discover any resources you may be aware of that we may share. This survey is confidential. Please have each person in your family fill this out separately.

What health or medical issues do you or a someone in your family have? Please check all that apply.

<input type="checkbox"/> Problems with stress <input type="checkbox"/> Someone ill at home <input type="checkbox"/> Substance abuse <input type="checkbox"/> Poor health habits <input type="checkbox"/> Loneliness, isolation <input type="checkbox"/> Grief and/or loss <input type="checkbox"/> Physical or emotional abuse <input type="checkbox"/> Relationship issues <input type="checkbox"/> Sexuality concerns	<input type="checkbox"/> Barriers to raising healthy children <input type="checkbox"/> Concerns with adult children <input type="checkbox"/> Need for spiritual renewal and focus <input type="checkbox"/> Chronic illness or disability <input type="checkbox"/> Primary caregiver for another person <input type="checkbox"/> Financial, legal, housing, job problems <input type="checkbox"/> End-of-life concerns <input type="checkbox"/> Other _____
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- Wellness includes your physical, emotional, spiritual, and relational well-being. What things do you do to enhance your wellness?

Please let us know what types of screening programs you would like to attend:

<input type="checkbox"/> Blood pressure (hypertension) screening <input type="checkbox"/> Blood sugar (diabetes) screening	<input type="checkbox"/> Stroke prevention screening <input type="checkbox"/> Other _____
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- If the FCN were available in the Faith Community Nurse/Education Office, would you be likely to take advantage of this opportunity to discuss your health? Yes No
 If yes, what times would be best for you:

Sunday, before service
 Sunday, after service
 Wednesday (before, during, after choir)
 Other _____

- Would you like the Faith Community Nurse to contact you regarding any health and wellness concerns?

Yes No Name: _____
 Preferred method: Text Phone Email

What ways would you like to see the FCN and Health + Wellness Team utilized in our church? Note: The FCN will work with our Parish Care Team, but not duplicate services.

<input type="checkbox"/> Health education <input type="checkbox"/> Personal health counseling <input type="checkbox"/> Transitional Care: hospital to home	<input type="checkbox"/> Screening programs, ie. blood pressure <input type="checkbox"/> Other _____
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- Please indicate your preferred time of day for health programs or group meetings:
 Evenings Days Morning Afternoon Day of the week Sunday
- Would you be interested in health programs or support groups using Zoom or another online platform?
 Note: You may use your telephone to participate in Zoom groups. Yes No

What health programs would you be interested in attending?	
<input type="checkbox"/> Health issues for children <input type="checkbox"/> Health issues for adolescents <input type="checkbox"/> Parenting skills classes <input type="checkbox"/> Stress and coping <input type="checkbox"/> Conflict management classes <input type="checkbox"/> Library of books/information on health issues <input type="checkbox"/> Advance Care Planning: Directives and Living Wills <input type="checkbox"/> Caregiving for others <input type="checkbox"/> Healthy eating <input type="checkbox"/> Community resources	<input type="checkbox"/> Study groups on health issues; various topics <input type="checkbox"/> Whole person health and wellness <input type="checkbox"/> Understanding medications <input type="checkbox"/> Understanding your Labs <input type="checkbox"/> First Aid Safety <input type="checkbox"/> CPR/AED <input type="checkbox"/> Signs of heart attack and stroke: When to call 911 <input type="checkbox"/> Mindfulness and meditation <input type="checkbox"/> Becoming more active <input type="checkbox"/> Other

Would you be interested in having any of these support groups available? Note: If something is not listed, we may be able to refer you to other support groups already available in the community.	
<input type="checkbox"/> Living with Chronic Illness <input type="checkbox"/> Loneliness <input type="checkbox"/> Healthy Eating <input type="checkbox"/> Supporting Adult Children with Needs	<input type="checkbox"/> Caregiving Others <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Other

- List any resources you know of in the congregation or community that might help develop and carry out any of the above activities:

- Please indicate if you have any of the following conditions. [This is for general information to help us direct our programs to your needs.]

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Lung/respiratory disease
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Cancer	<input type="checkbox"/> Weight concerns
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other

Your age: Under 20 20-29 30-39 40-49 50-59 60-69 70-70 >80

Do you: Live Alone Live with someone Live with family Live with extended family