WELLNESS WORKSHEETS

Twelfth Edition

Paul M. Insel • Walton T. Roth

The 126 Wellness Worksheets in this package are designed to help students become more involved in their own wellness and better prepared to implement behavior change programs. They include the following types of activities:

- Assessment tools that help students learn more about their wellness-related attitudes and behaviors.
- Internet activities that guide the students in finding and using wellness-related information on the Web.
- Knowledge-based reviews that increase students' comprehension of key concepts.

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Contents

* Worksheets that include an Internet activity

* Worksheets that include an Internet activity

62. Your Daily Diet Versus MyPyramid Recommendations
* 63. Putting MyPyramid Into Action: Healthier Choices Within Food Groups
64. How's Your Diet?
65. Determining Daily Energy and Macronutrient Intake Goals
66. Informed Food Choices
* 67. Reading Dietary Supplement Labels
68. Food Safety Quiz

Chapter 13 Exercise for Health and Fitness

69. Your Physical Activity Profile
70. Safety of Exercise Participation
71. Using a Pedometer to Track Physical Activity
72. Evaluating Your Fitness Level
73. Overcoming Barriers to Being Active
* 74. Personal Fitness Program Plan and Contract
75. Getting to Know Your Fitness Facility

Chapter 14 Weight Management

76. Body Image
77. What Triggers Your Eating?
78. Do You Feel Social Pressure to Eat?
79. Getting Started on a Weight-Loss Program
80. Identifying Weight-Loss Goals and Ways to Meet Them
81. Using Food Labels in Weight Management
82. Checklist for Evaluating Weight-Loss Books
83. Checklist for Evaluating Weight-Loss Products and Services
* 84. Diabetes Risk Assessment
85. Eating Disorder Checklist

Chapter 15 Cardiovascular Health

86. Facts About the Cardiovascular System
87. Screening for Heart Disease Risk Factors
* 88. Are You at Risk for Cardiovascular Disease?
89. Facts About Cardiovascular Disease
90. Hostility Quiz and Log

Chapter 16 Cancer

91. Facts About Cancer
* 92. Cancer Risk Factors and Prevention
93. Diet and Cancer
94. Skin Cancer Prevention
95. Performing an Oral Self-Exam

* Worksheets that include an Internet activity

* Worksheets that include an Internet activity

For Users of *Connect Core Concepts in Health* Brief Twelfth Edition

Brief Edition Chapter	Applicable Wellness Worksheets
1. Taking Charge of Your Health	1–9
2. Stress: The Constant Challenge	10–19
3. Psychological Health	20–28
4. Intimate Relationships and Communication	29–34, 37, 43
5. Sexuality, Pregnancy, and Childbirth	35–36, 38, 44–46
6. Contraception and Abortion	39–42
7. The Use and Abuse of Psychoactive Drugs	47–50
8. Alcohol and Tobacco	51–59
9. Nutrition Basics	60–68
10. Exercise for Health and Fitness	69–75
11. Weight Management	76–85
12. Cardiovascular Disease and Cancer	86–95
13. Immunity and Infection	96–102
14. Environmental Health	103–105
15. Conventional and Complementary Medicine	106–113
16. Personal Safety	114–120
17. The Challenge of Aging	121–126

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 1

Evaluate Your Lifestyle

All of us want optimal health. But many of us do not know how to achieve it. Taking this quiz, adapted from one created by the U.S. Public Health Service, is a good place to start. The behaviors covered in the test are recommended for most Americans. (Some of them may not apply to people with certain diseases or disabilities or to pregnant women, who may require special advice from their physicians.) After you take the quiz, add up your score for each section.

	Almost always	Sometimes	Never
Tobacco Use			
1. I avoid smoking cigarettes.	4	1	0
2. I avoid using a pipe or cigars.	2	1	0
3. I avoid spit tobacco.	2	1	0
4. I limit my exposure to environmental tobacco smoke.	2	1	0
Tobacco Score:	_____		
Alcohol and Other Drugs			
1. I avoid alcohol *or* I drink no more than 1 (women) or 2 (men) drinks a day.	4	1	0
2. I avoid using alcohol or other drugs as a way of handling stressful situations or problems in my life.	2	1	0
3. I am careful not to drink alcohol when taking medications, such as for colds or allergies, or when pregnant.	2	1	0
4. I read and follow the label directions when using prescribed and over-the-counter drugs.	2	1	0
Alcohol and Other Drugs Score:	_____		
Nutrition			
1. I eat a variety of foods each day, including seven or more servings of fruits and vegetables, depending on my calorie intake.	3	1	0
2. I limit the amount of total fat and saturated and trans fat in my diet.	3	1	0
3. I avoid skipping meals.	2	1	0
4. I limit the amount of salt and added sugar I eat.	2	1	0
Nutrition Score:	_____		
Exercise/Fitness			
1. I engage in moderate-intensity exercise for 150 minutes per week.	4	1	0
2. I maintain a healthy weight, avoiding being overweight or underweight.	2	1	0
3. I do exercises to develop muscular strength and endurance at least twice a week.	2	1	0
4. I spend some of my leisure time participating in physical activities such as gardening, bowling, golf, or baseball.	2	1	0
Exercise/Fitness Score:	_____		

(over)

WELLNESS WORKSHEET 1 — continued

Emotional Health	Almost always	Sometimes	Never
1. I enjoy being a student, and I have a job or do other work that I like.	2	1	0
2. I find it easy to relax and express my feelings freely.	2	1	0
3. I manage stress well.	2	1	0
4. I have close friends, relatives, or others I can talk to about personal matters and call on for help.	2	1	0
5. I participate in group activities (such as church and community organizations) or hobbies that I enjoy.	2	1	0

Emotional Health Score: _____

Safety			
1. I wear a safety belt while riding in a car.	2	1	0
2. I avoid driving while under the influence of alcohol or other drugs.	2	1	0
3. I obey traffic rules and the speed limit when driving.	2	1	0
4. I read and follow instructions on the labels of potentially harmful products or substances, such as household cleaners, poisons, and electrical appliances.	2	1	0
5. I avoid using a cell phone while driving.	2	1	0

Safety Score: _____

Disease Prevention			
1. I know the warning signs of cancer, diabetes, heart attack, and stroke.	2	1	0
2. I avoid overexposure to the sun and use sunscreens.	2	1	0
3. I get recommended medical screening tests (such as blood pressure checks and Pap tests), immunizations, and booster shots.	2	1	0
4. I practice monthly breast/testicle self-exams.	2	1	0
5. I am not sexually active *or* I have sex with only one mutually faithful, uninfected partner *or* I always engage in safer sex (using condoms) *and* I do not share needles to inject drugs.	2	1	0

Disease Prevention Score: _____

What Your Scores Mean

Scores of 9 and 10–Excellent! Your answers show that you are aware of the importance of this area to wellness. More important, you are putting your knowledge to work for you by practicing good health habits. As long as you continue to do so, this area should not pose a serious health risk.

Scores of 6–8–Your health practices in this area are good, but there is room for improvement.

Scores of 3–5–Your health risks are showing!

Scores of 0–2–Your answers show that you may be taking serious and unnecessary risks with your health.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 2

Wellness Profile

Fill in your strengths for each of the dimensions of wellness described below. Examples of strengths are listed with each dimension.

Physical wellness: To maintain overall physical health and engage in appropriate physical activity (e.g., stamina, strength, flexibility, healthy body composition).

_____

_____

_____

_____

Emotional wellness: To have a positive self-concept, deal constructively with your feelings, and develop positive qualities (e.g., optimism, trust, self-confidence, determination, persistence, dedication).

_____

_____

_____

_____

Intellectual wellness: To pursue and retain knowledge, think critically about issues, make sound decisions, identify problems, and find solutions (e.g., common sense, creativity, curiosity).

_____

_____

_____

_____

Spiritual wellness: To develop a set of beliefs, principles, or values that give meaning or purpose to your life; to develop faith in something beyond yourself (e.g., religious faith, service to others).

_____

_____

_____

_____

Interpersonal/social wellness: To develop and maintain meaningful relationships with a network of friends and family members and to contribute to the community (e.g., friendly, good-natured, compassionate, supportive, good listener).

_____

_____

_____

_____

Environmental wellness: To protect yourself from environmental hazards, and to minimize the negative impact of your behavior on the environment (e.g., carpools, recycling).

_____

_____

_____

_____

(over)

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Next, choose what you believe are your five most important strengths, and record them under "Core Wellness Strengths."

Core Wellness Strengths

1 _____

2 _____

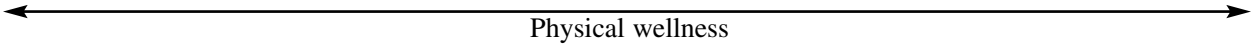
3 _____

4 _____

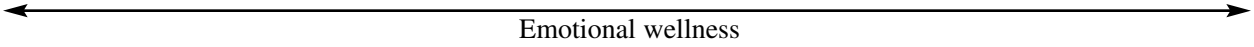
5 _____

Finally, mark on the continuums below where you think you fall for each dimension.

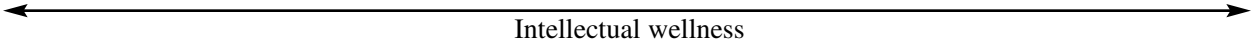
Low Level of Wellness	Physical, Psychological, Emotional Symptoms	Change and Growth	High Level of Wellness



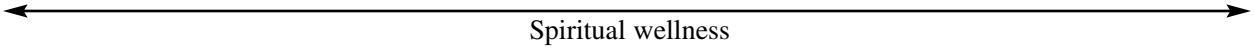
Physical wellness



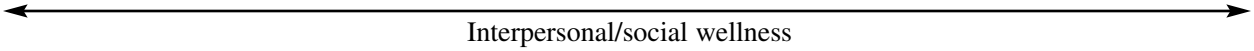
Emotional wellness



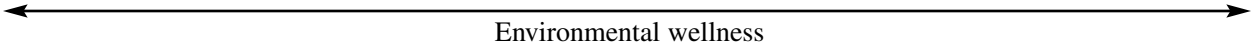
Intellectual wellness



Spiritual wellness



Interpersonal/social wellness



Environmental wellness

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 3

Stages of Change

The stages of change model of behavior change includes six well-defined stages that people move through as they work to change a target behavior. It is important to determine what stage you are in now so that you can choose appropriate techniques for progressing through the cycle of change.

Target behavior/problem: _____

Goal of behavior change: _____

Examples of target behaviors include smoking, eating candy bars every afternoon, and never wearing a safety belt; the goal of your behavior change program might be quitting smoking, eating only one candy bar per week, or wearing a safety belt every time you are a driver or passenger in a car.

Part I. Assess Your Stage

To determine your stage, check true or false for each of the following statements:

True	False	
_____	_____	1. I changed my target behavior more than 6 months ago.
_____	_____	2. I changed my target behavior within the past 6 months.
_____	_____	3. I intend to take action in the next month and have already made a few small changes in my behavior.
_____	_____	4. I intend to take action on my target behavior in the next 6 months.

Find the stage that corresponds to your responses:

False for all four statements = Precontemplation

True for statement 4, false for statements 1–3 = Contemplation

True for statements 3 and 4, false for statements 1 and 2 = Preparation

True for statement 2, false for statement 1 = Action

True for statement 1 = Maintenance

Part II. Strategies for Change

To help you move forward in the cycle of change, try the techniques and strategies listed below for your stage. (You may find it helpful to work through the strategies for all the stages.) Put a check next to any strategy that you complete.

Precontemplation

_____ Investigate your target behavior—make a list of the ways it affects you now and how it may affect you in the future:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(over)

_____ Become aware of the mental defenses you use to resist change; examples of defenses include denying the consequences of your target behavior and rationalizing your reasons for not changing. List some of the key mental defense mechanisms that you use to resist change:

_____ _____

_____ _____

_____ _____

_____ Enlist friends and family members to help you learn more about your target behavior and the defenses that block your progress. List the people you have spoken with, and briefly describe what they told you about the defense mechanisms you use:

_____

_____

_____

_____

_____ Identify and list community resources that can help you change your target behavior—for example, a stop-smoking program or a stress-management workshop:

_____ _____

_____ _____

Contemplation

_____ Engage your emotions through strategies such as imagining your life without changing, watching movies related to your target behavior, and becoming more aware of the current effects of your target behavior (for example, blow cigarette smoke or spit tobacco juice into a white handkerchief, have someone videotape you while you are drunk or hung over, or make a pile of the amount of candy or junk food you eat in a month). List the strategies you tried:

_____ _____

_____ _____

_____ Keep a journal of your target behavior to establish a baseline. Examine the behaviors that lead up to and follow your target behavior (see Wellness Worksheet 4).

_____ Complete a cost-benefit analysis of your target behavior:

Pros of current behavior: Cons of current behavior:

_____ _____

_____ _____

_____ _____

Pros of changing: Cons of changing:

_____ _____

_____ _____

_____ _____

(over)

_____ Create a new self-image: Describe yourself and your life after you change your target behavior:

_____

_____

_____

_____

_____ Enlist the help of friends and family members to support your efforts and help you identify the causes and consequences of your target behavior. List the people you've spoken with, and briefly describe what they told you about your target behavior:

_____

_____

_____

_____

Preparation

_____ Make change a priority in your life; plan to commit the necessary time and effort to change.

_____ Create a specific plan for change, and complete a contract (see Wellness Worksheet 5).

_____ Tell the people in your life about the change you'll be making, and enlist their help. List the people you've spoken with and how they will help in your program for change:

_____

_____

_____

_____

Action

See Chapter 1 in your text for a detailed discussion of strategies for the action stage of change.

_____ Use a journal to monitor your behavior.

_____ Substitute healthier responses for your problem behavior. Complete Wellness Worksheet 4 to help you identify ways to break the chain of events that leads to your target behavior.

_____ Manage your stress level, and don't let yourself get overwhelmed. (See Chapter 2 in your text for a detailed discussion of stress-management techniques.) List three strategies you'll use to help manage stress during your behavior change program:

_____

_____

_____

(over)

_____ Practice positive, realistic self-talk (see Chapter 3 in your text).

_____ Make changes in your environment that will discourage your target behavior and encourage healthier choices. Identify cues that trigger your target behavior and develop strategies for avoiding them or making different choices (complete Wellness Worksheet 4).

_____ Give yourself the rewards you named in your contract (Wellness Worksheet 5) as well as plenty of self-praise.

_____ Involve the people around you. Find a buddy to work with you on change and/or find a role model who has already made the change you are working toward and who can provide both inspiration and practical advice.

Buddy:_____

Role model:_____

_____ Keep a positive attitude about yourself and the change you are attempting. Don't get discouraged—the action stage typically lasts for at least several months.

Maintenance

Continue with all the positive strategies you used in the action stage.

_____ Continue to monitor your behavior with a journal.

_____ Continue to manage your environment.

_____ Continue to practice realistic self-talk.

_____ Guard against slips, but don't let a slip set you back. Be prepared for complications.

_____ Help someone else make the change that you have just made. (Person to help:

_____.)

Termination

If you complete the previous five stages and are no longer tempted to lapse back to your target behavior, you are in the termination stage. You have a new self-image, positive feelings of self-efficacy, and a healthier lifestyle.

For more on the stages of change model and many additional practical strategies, see the text *Changing for Good* by James Prochaska, John Norcross, and Carlo DiClemente (Avon Books).

SOURCE: Prochaska, J. O., J. C. Norcross, and C. C. DiClemente. 1994. *Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward.* New York: Avon Books.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 4

Breaking Behavior Chains

Select a wellness-related behavior you think you might like to change. Examples are smoking cigarettes, eating candy bars every night, and not wearing a safety belt.

Target behavior_____

Use your health journal to collect information about your target behavior—what leads up to it and what follows it. By tracing this chain of events, you'll be able to identify points in the chain where you can make a change. The partial behavior chain below shows a sequence of events for a person who wants to add exercise to a daily routine—but who winds up snacking and watching TV instead. By examining the chain carefully, you can identify ways to break it at every step. After you review this sample, go through the same process for a typical chain of events involving your target behavior; use the blank behavior chain on the next page.

Sample Chain of Events	Strategies for Breaking Chain
Come home from class	You plan an afternoon walk as part of your exercise program.
Feel tired, not like exercising	Tell yourself you'll feel better and more alert after working out.
Look for walking shoes; can't find them	Put shoes and clothes for exercise in an obvious place the night before.
Feel annoyed	Remind yourself of your program goals, and tell yourself that you can stick with it.
Go into kitchen, see food, and feel hungry	Stay out of the kitchen unless you will be fixing or eating a planned meal or snack.
Grab a soda and a bag of chips	Have a glass of water or a preprepared healthy snack.
Turn on TV and sit down	Turn on the radio instead; listen to news or music while you get ready to exercise.
Eat chips, watch TV	If you like afternoon TV, work out in the morning or exercise in front of the TV on a stationary bike or treadmill.
Feel guilty	Even if you do have occasional lapses, don't beat yourself up. Think positively about how you'll resume your program the next day.

(over)

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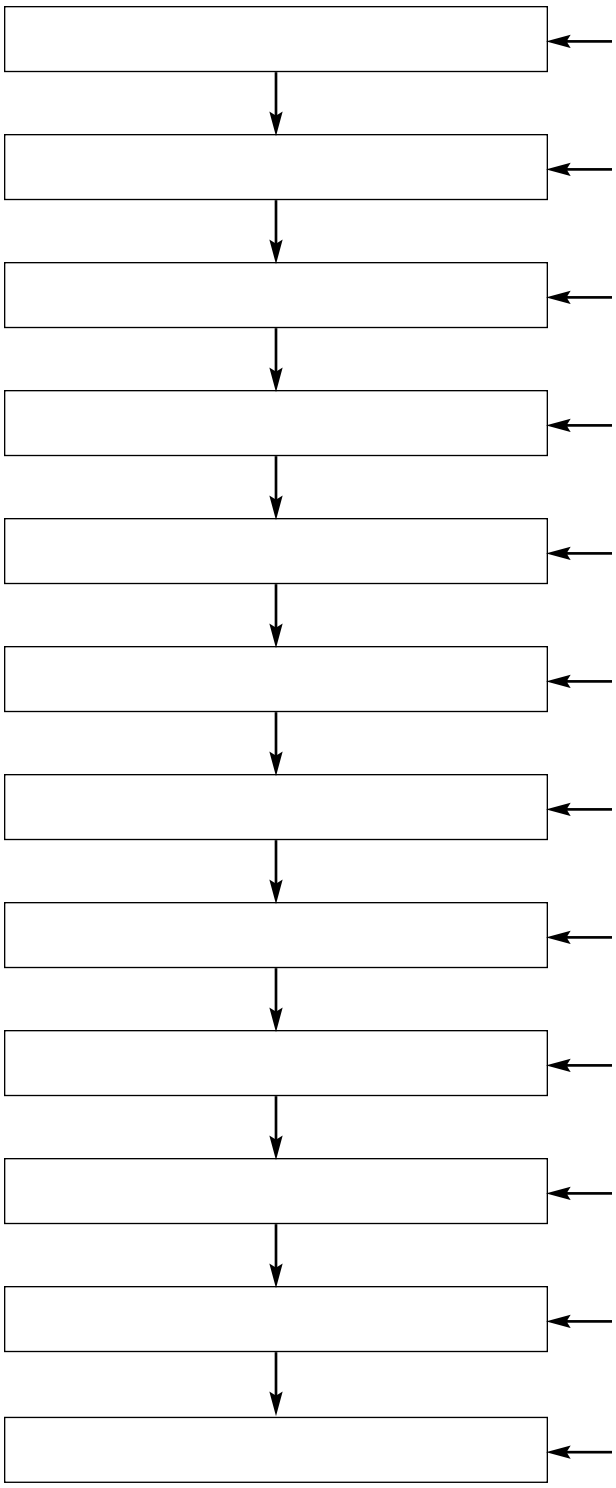
Chain of Events **Strategies for Breaking Chain**



SOURCE: Fahey, T. D., P. M. Insel, and W. T. Roth. 2011. *Fit & Well: Core Concepts and Labs in Physical Fitness and Wellness,* 9th ed. New York: McGraw-Hill. Copyright © 2011 The McGraw-Hill Companies. Reprinted with permission from The McGraw-Hill Companies.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 5

Behavior Change Contract

Once you have chosen a behavior you wish to change and have identified ways to change it (see Wellness Worksheet 4), your next step is to sign a behavior change contract. Your contract should show your commitment to changing your behavior and include details of your program. Use the contract shown below, or devise one that more closely fits your goals and your program.

(1) I _____ (name) agree to _____ (specify behavior you want to change)

_____

_____.

(2) I will begin on _____ (start date) and plan to reach my goal of _____ (specify final goal)

_____

by _____ (final target date).

(3) In order to reach my final goal, I have devised the following schedule of minigoals. For each step in my program, I will give myself the reward listed.

_____ (minigoal 1) _____ (target date) _____ (reward)

_____ (minigoal 2) _____ (target date) _____ (reward)

_____ (minigoal 3) _____ (target date) _____ (reward)

My overall reward for reaching my final goal will be _____.

(4) I have gathered and analyzed data on my target behavior and have identified the following strategies for changing my behavior: _____

_____

_____.

(5) I will use the following tools to monitor my progress toward reaching my final goal:

_____ (list any charts, graphs, or journals you plan to use)

_____.

I sign this contract as an indication of my personal commitment to reach my goal.

_____ (your signature) _____ (date)

I have recruited a helper who will witness my contract and _____

_____ (list any way in which your helper will participate in your program).

_____ (witness's signature) _____ (date)

(over)

Describe any special strategies you will use to help change your behavior:

Create a plan below for any type of chart, graph, or journal you will use to monitor your progress:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 6

Levenson Multidimensional Locus of Control Scales

For each of the following statements, indicate the extent to which you agree or disagree by writing in the appropriate number.

–3 = strongly disagree
–2 = disagree somewhat
–1 = slightly disagree
+1 = slightly agree
+2 = agree somewhat
+3 = strongly agree

_____ 1. Whether or not I get to be a leader depends mostly on my ability.
_____ 2. To a great extent my life is controlled by accidental happenings.
_____ 3. I feel like what happens in my life is mostly determined by powerful people.
_____ 4. Whether or not I get into a car accident depends mostly on how good a driver I am.
_____ 5. When I make plans, I am almost certain to make them work.
_____ 6. Often there is no chance of protecting my personal interests from bad luck.
_____ 7. When I get what I want, it's usually because I'm lucky.
_____ 8. Although I might have good ability, I will not be given leadership responsibility without appealing to those in positions of power.
_____ 9. How many friends I have depends on how nice a person I am.
_____ 10. I have often found that what is going to happen will happen.
_____ 11. My life is chiefly controlled by powerful others.
_____ 12. Whether or not I get into a car accident is mostly a matter of luck.
_____ 13. People like myself have very little chance of protecting our personal interests when they conflict with those of strong pressure groups.
_____ 14. It's not always wise for me to plan too far ahead because many things turn out to be a matter of good or bad fortune.
_____ 15. Getting what I want requires pleasing those people above me.
_____ 16. Whether or not I get to be a leader depends on whether I'm lucky enough to be in the right place at the right time.
_____ 17. If important people were to decide they didn't like me, I probably wouldn't make many friends.
_____ 18. I can pretty much determine what will happen in my life.
_____ 19. I am usually able to protect my personal interests.
_____ 20. Whether or not I get into a car accident depends mostly on the other driver.
_____ 21. When I get what I want, it's usually because I worked hard for it.
_____ 22. In order to have my plans work, I make sure that they fit in with the desires of people who have power over me.
_____ 23. My life is determined by my own actions.
_____ 24. It's chiefly a matter of fate whether or not I have a few friends or many friends.

(over)

Scoring

Total your responses for the items listed for each of the three parts of the scale; add +24 to each of your three totals.

Internal Locus of Control: Total your responses for items 1, 4, 5, 9, 18, 19, 21, and 23; then add +24.

Score: _____

Powerful Others: Total your responses for items 3, 8, 11, 13, 15, 17, 20, and 22; then add +24.

Score: _____

Chance: Total your responses for items 2, 6, 7, 10, 12, 14, 16, and 24; then add +24.

Score: _____

Your scores should be between 0 and 48. A high rating on the Internal Locus of Control scale indicates that you have a strong internal locus of control. An internal locus of control can be helpful for successful behavior change.

High ratings on either the Powerful Others scale or the Chance scale indicate a strong external locus of control. If you rate high on the Powerful Others scale, you typically believe that your fate is controlled by other people; if you rate high on the Chance scale, you believe your fate is controlled by chance.

QUIZ SOURCE: Levenson, H. 1973. Multidimensional locus of control in psychiatric patients. *Journal of Consulting and Clinical Psychology* 41:397–404. Copyright © 1973 by the American Psychological Association. Adapted with permission.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 7

Occupational Wellness

To the six dimensions of wellness described in your text, some researchers add a seventh: occupational wellness. If you consider the total amount of time you will spend in the workplace over your lifetime, you can see how important occupational wellness is to your sense of well-being. Occupational wellness means that through your work, you gain personal satisfaction, find enrichment and meaning, build useful skills, and contribute to your community. It requires successful time management, stress reduction, and communication and negotiation. The following questions can help you discover more about what occupational wellness means to you and how to achieve it.

Values

In each of the following categories, put a check next to any item that is true for your job or life now and a plus sign in front of any item that you would like to develop more.

Career values: In my occupation, I do (✔); I would like to (+):

____	Create beauty	____	Help people	____	Organize things
____	Create ideas	____	Improve society	____	Perform physical tasks
____	Experience variety	____	Make things	____	Take responsibility
____	Follow directions	____	Manage people		

Result values: I have (✔); I'd like to have more (+):

____	Adventure	____	Independence	____	Power
____	Beautiful surroundings	____	Leisure time	____	Prestige
____	Comfort	____	Money	____	Security
____	Fun	____	Possessions	____	Structure
____	Happiness				

Personal qualities: I am (✔); I'd like to be more (+):

____	Accepting	____	Cooperative	____	Honest/fair
____	Affectionate	____	Courteous	____	Intelligent
____	Ambitious	____	Creative	____	Joyful
____	Balanced	____	Decisive	____	Kind
____	Brave	____	Disciplined	____	Loving
____	Calm	____	Efficient	____	Loyal
_____	Caring	____	Enthusiastic	____	Mature
____	Compassionate	____	Famous	____	Neat
____	Competitive	____	Friendly	____	Needed
____	Confident	____	Good-looking	____	Optimistic
____	Conscientious	____	Healthy	____	Peaceful

(over)

____	Poised	____	Strong	____	Verbal
____	Prompt	____	Successful	____	Warm
____	Self-accepting	____	Trusting	____	Wise
____	Sensitive	____	Understanding		

Skills

For each of the following occupation-related qualities, rate your current status (1–5): 1 indicates that your skills are limited in an area and 5 indicates a significant personal strength. Also place a plus sign (+) next to the qualities that you'd like to develop further. Circle the names of any skills that you think are or will be important in your working life.

____ *Logical intelligence:* Think, observe, plan, analyze, evaluate, understand, solve problems; put ideas and information together to deal with complex operations; plan and organize work; keep track of verbal and numerical information in an orderly way; make decisions using common sense based on practical experience.

____ *Intuitive intelligence:* Imagine, compare, see things holistically, decide based on best guesses and intuitive common sense rather than rules or measurements; use words, numbers, or symbols creatively; develop new ideas, new processes, new combinations.

____ *Verbal ability:* Use words to read, research, write, listen, record, discuss, direct, instruct, communicate, motivate.

____ *Numerical ability:* Use numbers and symbols to measure, figure, calculate, estimate, keep books, budget, analyze.

____ *Exactness with detail:* Follow directions exactly; make decisions based on set rules or measurements; attend to small details in proofreading words, numbers, symbols, and/or diagrams or in examining lines and shapes of products.

____ *Facility with multidimensional form:* Understand, visualize, relate two- or three-dimensional lines or shapes, spaces, shading—sometimes in color.

____ *Facility in businesslike contact with people:* Manage, supervise, organize, motivate, entertain, train, serve, negotiate with, cooperate with people.

____ *Ability to influence people:* Persuade/inspire others to think or behave in certain ways; teach, exchange, interpret ideas/facts/feelings; help others solve personal problems.

____ *Finger/hand agility:* Use fingers/hands to make, repair, process, test, assemble, operate various products/machines/tools using special techniques, sometimes very complex.

____ *Whole body agility:* Use the whole body to handle, carry, lift, move, balance, or coordinate itself or physical objects.

(over)

Values and Skills: A Summary

Write a brief summary of the items you've marked in the previous two sections. What do you value, and what are your current and target skills? What does this say about the type of occupation you should have in order to achieve occupational wellness?

Past and Current Jobs

Briefly describe your current occupation and any past jobs. Rate them according to some of the major characteristics of occupational wellness, including satisfaction, meaning, and consistency with your key values and skills/strengths:

Goals

What lifestyle would you like to have? Describe your ideals in areas such as home, clothing, food, family, friends, associates, transportation, pets, gadgets, activities and hobbies, and travel:

(over)

If you could instantly have the job of your dreams, what would it be? If your goal were to please yourself and your family, what would it be? If your goal were to improve the world, what would it be?

Moving Forward

Look back over all your lists and pick an area for improvement or development. What specific steps, large or small, can you take to improve this area of your life to boost your current or future occupational wellness? If necessary, see a counselor to talk over problem areas or values conflicts.

Area to improve: _____

Steps to take:

SOURCE: Adapted from Michelozzi, B. N. 2004. *Coming Alive from Nine to Five in a 24/7 World,* 7th ed. New York: McGraw-Hill. Copyright © 2004 by The McGraw-Hill Companies, Inc. Reprinted with permission from The McGraw-Hill Companies.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 8

Create a Family Health Portrait

The Surgeon General's Family History Initiative encourages all American families to learn more about their family history. Knowing your family health history is a powerful guide to understanding risk for disease. However, keep in mind that a family history of a particular illness may increase risk, but it almost never guarantees that other family members will develop the illness.

To get the most accurate health history information, it is important to talk directly with your relatives. Explain to them that their health information can help improve prevention and screening of diseases for all family members.

Start by asking your relatives about any health conditions they have had—including history of chronic illnesses, such as heart disease; pregnancy complications, such as miscarriage; and any developmental disabilities. (You may want to refer to Wellness Worksheet 45 for a list of conditions and diseases.) Get as much specific information as possible. It is most useful if you can list the formal name of any medical condition that has affected you or your relatives. You can get help finding information about health conditions that have affected you and your family members—living or deceased—by asking relatives or health care professionals for information or by getting copies of medical records. If you are planning to have children, you and your partner should each create a family health portrait and show it to your health care professional.

The Family Health Portrait chart on the following pages will help you collect and organize your family information. (You can also complete a family health history at http://familyhistory.hss.gov.) No form can reflect every version of the American family, so use this chart as a starting point and adapt it to your family's needs. First, complete the personal information, including the number of relatives you have in each category and whether you have any of the six conditions listed. Then complete the family information, including any health conditions your family members have, their age at diagnosis, and, if they are deceased, the age at which they died. Because some conditions are more common in people with certain ethnic ancestries, you may also want to record your relatives' ancestry or country of origin under their names.

Once you complete the Family Health Portrait, take it to your health care professional so that he or she can better individualize your health care. Be sure to make a copy for your records and update it as circumstances change or you learn more about your family's health history.

(over)

Personal Information

Name: **(Last)**_____

(First)_____

Date of Birth _____

Are you an identical twin? Yes___ No___

Record the number of family members you have in the box below. These are the family members who are most relevant to your health history.

Number of family members *Related by blood, living or deceased*	
Grandparents:	4
Mother:	1
Father:	1
Aunts:	
Uncles:	
Sisters:	
Brothers:	
Daughters:	
Sons:	
Half sisters:	
Half brothers:	

Record whether you have any of the 6 conditions listed below. These diseases are tracked because they are common and we have very good information about how to avoid them.

In the spaces labeled "Other," enter other diseases or conditions you have.

	Do you have any of these health conditions?	Yes/no	**Age at Diagnosis**
	Heart disease		
	Stroke		
	Diabetes		
	Colon cancer		
	Breast cancer		
	Ovarian cancer		
Other			

(over)

Family Information

List below your blood relatives and the illnesses they may have suffered, even if you do not know the medical name. Refer back to the box, "Number of Family Members" so you don't forget anyone. Fill in as much information as you can. Be sure to report diseases such as heart disease, stroke, diabetes, or cancer (especially colon, breast, or ovarian cancers) that have occurred in your family.

FAMILY *(BLOOD RELATED ONLY)*	RELATIVE'S NAME	RELATIONSHIP TO YOU	TWIN? (Y/N)	HEALTH CONDITION	AGE AT DIAGNOSIS	LIVING? (Y/N)	AGE AT DEATH
IMMEDIATE *(brothers, sisters, parents, children)*							
MOTHER'S *(her father, her mother, her sisters, her brothers)*							

(over)

FAMILY (BLOOD RELATED ONLY)	RELATIVE'S NAME	RELATIONSHIP TO YOU	TWIN? (Y/N)	HEALTH CONDITION	AGE AT DIAGNOSIS	LIVING? (Y/N)	AGE AT DEATH
MOTHER'S CONTINUED							
FATHER'S *(his father, his mother, his sisters, his brothers)*							

SOURCE: Department of Health and Human Services. 2007. The Surgeon General's Family History Initiative: My Family Health Portrait (http://www.hhs.gov/familyhistory; retrieved November 19, 2008).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 9

Wellness on the Web

The World Wide Web can be an important source of up-to-date wellness information. In the first part of this worksheet, you'll practice navigating around a Web site; in the second part, you'll use a search engine to find information on a particular topic.

Part I. Explore a Web Site

Choose one of the sites listed below, and enter the address (uniform resource locator, or URL) into your Web browser.

Centers for Disease Control and Prevention: http://www.cdc.gov

FirstGov for Consumers: Health:

Healthfinder: http://www.healthfinder.gov

National Institutes of Health: http://www.nih.gov

National Library of Medicine MedlinePlus: http://medlineplus.gov

Site chosen (URL): _____

The home page of the site should have a menu of the information available at the site. Choose two items to explore. Click on each one in turn, and briefly describe what you find.

1. Menu item: _____

   Description: _____

   _____

   _____

   _____

2. Menu item: _____

   Description: _____

   _____

   _____

   _____

Check the Web site you've chosen for the following other features and circle "yes" or "no":

Yes No Does the Web site have links to other sites? About how extensive is the list of links? Is it organized in an easy-to-use fashion?

_____

_____

_____

(over)

Yes No Does the site have an index, a contents page, or search capability? If so, is it easy to use?

Yes No Does the site give a "last modified" date? If so, note it below. Are there any other indications of currency, such as an "in the news," "what's new," or "late-breaking information" section?

Yes No Is there a mission statement or an "about us" section that tells more about the sponsor(s) of the site? Are there any indications of potential bias? How would you rate the overall reliability of the site?

Yes No Is there an e-mail address for a contact person or department? If so, note it below:

Choose one topic and follow a series of links to the most specific level. For example, at the Healthfinder site, you can click in turn on Health A–Z, "N," Nutrition, and the Dietary Guidelines for Americans 2005.

Topic: _____

Brief description of the most specific level of information: _____

Are you still on a page affiliated with the site you started with? Does the first part of your current URL match that of the home page of the original site?

Current URL: _____

If not, can you determine what organization or agency sponsors or maintains the current site?

Finally, what are your overall impressions of the site? Did it provide helpful, reliable information? Was it easy and enjoyable to use? What improvements would you recommend for the site?

(over)

Part II. Search the Web

Choose a specific topic to investigate—for example, skin cancer prevention, bulimia, home HIV or hepatitis tests, or binge drinking by college students. Use the search engine that accompanies your browser or another one of your choosing.

When you are searching, it's best to make your searches as specific as possible. Searching for key words like "fitness" or "cancer" will yield millions of matches. You are better off searching with more specific phrases—"energy drinks" or "breast cancer treatments," for example.

Topic chosen: _____

Once you've completed your search, choose two of the sites to investigate. Write a brief description of each one; include your evaluation of the site's reliability, currency, and usefulness.

1. URL: _____

   Sponsor: _____

   Description of site: _____

   _____

   _____

   Does the site seem reliable? Why or why not? _____

   _____

   _____

   Does the site seem current? Why or why not? _____

   _____

   _____

   Is the site easy to use and helpful? Why or why not? _____

   _____

   _____

2. URL: _____

   Sponsor: _____

   Description of site: _____

   _____

   _____

   Does the site seem reliable? Why or why not? _____

   _____

   _____

(over)

Does the site seem current? Why or why not? _____

_____

_____

Is the site easy to use and helpful? Why or why not?_____

_____

_____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 10

Identify Your Stress Level and Your Key Stressors

Many symptoms of excess stress are easy to self-diagnose. To help determine how much stress you experience on a daily basis, answer the following questions.

How many of the symptoms of excess stress in the list below do you experience frequently? _____

Yes	No	
____	____	1. Are you easily startled or irritated?
____	____	2. Are you increasingly forgetful?
____	____	3. Do you have trouble falling or staying sleep?
____	____	4. Do you continually worry about events in your future?
____	____	5. Do you feel as if you are constantly under pressure to produce?
____	____	6. Do you frequently use tobacco, alcohol, or other drugs to help you relax?
____	____	7. Do you often feel as if you have less energy than you need to finish the day?
____	____	8. Do you have recurrent stomachaches or headaches?
____	____	9. Is it difficult for you to find satisfaction in simple life pleasures?
____	____	10. Are you often disappointed in yourself and others?
____	____	11. Are you overly concerned with being liked or accepted by others?
____	____	12. Have you lost interest in intimacy or sex?
____	____	13. Are you concerned that you do not have enough money?

Experiencing some of the stress-related symptoms or answering "yes" to a few questions is normal. However, if you experience a large number of stress symptoms or you answered "yes" to a majority of the questions, you are likely experiencing a high level of stress. Take time out to develop effective stress-management techniques. Many coping strategies that can aid you in dealing with your college stressors are described in Chapter 2 of your text. Additionally, your school's counseling center can provide valuable support.

Symptoms of Excess Stress

Physical Symptoms	Emotional Symptoms	Behavioral Symptoms
Dry mouth	Anger	Crying
Excessive perspiration	Anxiety or edginess	Disrupted eating habits
Frequent illnesses	Depression	Disrupted sleeping habits
Gastrointestinal problems	Fatigue	Harsh treatment of others
Grinding of teeth	Hypervigilance	Increased use of tobacco, alcohol, or other drugs
Headaches	Impulsiveness	Problems communicating
High blood pressure	Inability to concentrate	Sexual problems
Pounding heart	Irritability	Social isolation
Stiff neck or aching lower back	Trouble remembering things	

Weekly Stress Log

Now that you are familiar with the signals of stress, complete the weekly stress log on the next page to map patterns in your stress levels and identify sources of stress. Enter a score for each hour of each day according to the ratings listed below the log.

(over)

	A.M.							P.M.											
	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	*Average*
Monday																				
Tuesday																				
Wednesday																				
Thursday																				
Friday																				
Saturday																				
Sunday																				
Average																				

Ratings

1 = No anxiety; general feeling of well-being
2 = Mild anxiety; no interference with activity
3 = Moderate anxiety; specific signal(s) of stress present
4 = High anxiety; interference with activity
5 = Very high anxiety and panic reactions; general inability to engage in activity

To identify daily or weekly patterns in your stress level, average your stress rating for each hour and each day. For example, if your scores for 6:00 A.M. are 3, 3, 4, 3, and 4, with blanks for Saturday and Sunday, your 6:00 A.M. rating would be 17 ÷ 5, or 3.4 (moderate to high anxiety). Finally, calculate an average weekly stress score by averaging your daily average stress scores. Your weekly average will give you a sense of your overall level of stress.

Identifying Sources of Stress

External stressors: List several people, places, or events that caused you a significant amount of discomfort this week: _____

_____

_____

_____

Internal stressors: List any recurring thoughts or worries that produced feelings of discomfort this week:

_____

_____

_____

_____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 11

Major Life Events and Stress

To get a feel for the possible health impact of the various recent events or changes in your life, think back over the past year and circle the points listed for each of the events that you experienced during that time.

Health

An injury or illness that:	
kept you in bed a week or more, or sent you to the hospital	74
was less serious than that	44
Major dental work	26
Major change in eating habits	27
Major change in sleeping habits	26
Major change in your usual type or amount of recreation	28

Work

Change to a new type of work	51
Change in your work hours or conditions	35
Change in your responsibilities at work:	
more responsibilities	29
fewer responsibilities	21
promotion	31
demotion	42
transfer	32
Troubles at work:	
with your boss	29
with coworkers	35
with persons under your supervision	35
other work troubles	28
Major business adjustment	60
Retirement	52
Loss of job:	
laid off from work	68
fired from work	79
Online course to help you in your work	18

Home and Family

Major change in living conditions	42
Change in residence:	
move within the same town or city	25
move to a different town, city, or state	47
Change in family get-togethers	25
Major change in health or behavior of family member	55
Marriage	50
Pregnancy	67
Miscarriage or abortion	65
Gain of a new family member:	
birth of a child	66
adoption of a child	65
a relative moving in with you	59
Spouse beginning or ending work	46
Child leaving home:	
to attend college	41
due to marriage	41
for other reasons	45
Change in arguments with spouse	50
In-law problems	38
Change in marital status of your parents:	
divorce	59
remarriage	50
Separation from spouse:	
due to work	53
due to marital problems	76
Divorce	96
Birth of grandchild	43
Death of spouse	119
Death of other family member:	
child	123
brother or sister	102
parent	100

(over)

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Personal and Social	
Change in personal habits	26
Beginning or ending school or college	38
Change of school or college	35
Change of political beliefs	24
Change in religious beliefs	29
Change in social activities	27
Vacation trip	24
New, close, personal relationship	37
Engagement to marry	45
Girlfriend or boyfriend problems	39
Sexual difficulties	44
Break-up of a close personal relationship	47
An accident	48
Minor violation of the law	20
Being held in jail	75
Death of a close friend	70
Major decision about your immediate future	51
Major personal achievement	36

Financial	
Major change in finances:	
increased income	38
decreased income	60
investment or credit difficulties	56
Loss or damage of personal property	43
Moderate purchase	20
Major purchase	37
Foreclosure on a mortgage or loan	58

Total score: _____

Scoring

Add up your points. A total score of anywhere from about 250 to 500 or so would be considered a moderate amount of stress. If you score higher than that, you may face an increased risk of illness; if you score lower than that, consider yourself fortunate.

SOURCE: Adapted from Miller, M. A., and R. H. Rahe. 1997. Life changes scaling for the 1990s. *Journal of Psychosomatic Research* 43(3): 279–292. Copyright 1997, with permission from Elsevier.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 12

Daily Hassles and Stress

For each of the following experiences, indicate to what degree it has been a part of your life *over the past month* by writing in the appropriate number.

1 = not at all part of my life
2 = only slightly part of my life
3 = distinctly part of my life
4 = very much part of my life

____ 1. Disliking your daily activities

____ 2. Lack of privacy

____ 3. Disliking your work

____ 4. Ethnic or racial conflict

____ 5. Conflicts with in-laws or boyfriend's/girlfriend's family

____ 6. Being let down or disappointed by friends

____ 7. Conflict with supervisor(s) at work

____ 8. Social rejection

____ 9. Too many things to do at once

____ 10. Being taken for granted

____ 11. Financial conflicts with family members

____ 12. Having your trust betrayed by a friend

____ 13. Separation from people you care about

____ 14. Having your contributions overlooked

____ 15. Struggling to meet your own standards of performance and accomplishment

____ 16. Being taken advantage of

____ 17. Not enough leisure time

____ 18. Financial conflicts with friends or fellow workers

____ 19. Struggling to meet other people's standards of performance and accomplishment

____ 20. Having your actions misunderstood by others

____ 21. Cash-flow difficulties

____ 22. A lot of responsibilities

____ 23. Dissatisfaction with work

____ 24. Decisions about intimate relationship(s)

____ 25. Not enough time to meet your obligations

____ 26. Dissatisfaction with your mathematical ability

(over)

____ 27. Financial burdens

____ 28. Lower evaluation of your work than you think you deserve

____ 29. Experiencing high levels of noise

____ 30. Adjustments to living with unrelated person(s) (e.g., roommate)

____ 31. Lower evaluation of your work than you hoped for

____ 32. Conflicts with family member(s)

____ 33. Finding your work too demanding

____ 34. Conflicts with friend(s)

____ 35. Hard effort to get ahead

____ 36. Trying to secure loan(s)

____ 37. Getting "ripped off" or cheated in the purchase of goods

____ 38. Dissatisfaction with your ability at written expression

____ 39. Unwanted interruptions of your work

____ 40. Social isolation

____ 41. Being ignored

____ 42. Dissatisfaction with your physical appearance

____ 43. Unsatisfactory housing conditions

____ 44. Finding work uninteresting

____ 45. Failing to get money you expected

____ 46. Gossip about someone you care about

____ 47. Dissatisfaction with your physical fitness

____ 48. Gossip about yourself

____ 49. Difficulty dealing with modern technology (e.g., computers)

____ 50. Car problems

____ 51. Hard work to look after and maintain home

Scoring

Add up your responses and find your total below.

≥ 136	Very high stress
116–135	High stress
76–115	Average stress
56–75	Low stress
51–55	Very low stress

QUIZ SOURCE: Kohn, P. M., and J. E. MacDonald. 1992. The survey of recent life experiences: A decontaminated hassles scale for adults. *Journal of Behavioral Medicine* 15:221–236. Copyright © 1992 by Plenum Publishing Corporation. With kind permission of Springer Science and Business Media.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 13

Time Stress Questionnaire

The following list describes time-related difficulties people sometimes experience. Please indicate how often each is a difficulty for you, using the numbers shown.

0 = Seldom or never a difficulty for me
1 = Sometimes a difficulty for me
2 = Frequently a difficulty for me

____ 1. My time is directed by factors beyond my control

____ 2. Interruptions

____ 3. Chronic overload—more to do than time available

____ 4. Occasional overload

____ 5. Chronic underload—too little to do in time available

____ 6. Occasional underload

____ 7. Alternating periods of overload and underload

____ 8. Disorganization of my time

____ 9. Procrastination

____ 10. Separating home, school, and work

____ 11. Transition from work or school to home

____ 12. Finding time for regular exercise

____ 13. Finding time for daily periods of relaxation

____ 14. Finding time for friendships

____ 15. Finding time for family

____ 16. Finding time for vacations

____ 17. Easily bored

____ 18. Saying "yes" when I later wish I had said "no"

____ 19. Feeling overwhelmed by large tasks over an extended period of time

____ 20. Avoiding important tasks by frittering away time on less important ones

____ 21. Feeling compelled to assume responsibilities in groups

____ 22. Unable to delegate because no one to delegate to

____ 23. My perfectionism creates delays

____ 24. I tend to leave tasks unfinished

____ 25. I have difficulty living with unfinished tasks

____ 26. Too many projects going at one time

(over)

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____ 27. Getting into time binds by trying to please others too often

____ 28. I tend to hurry even when it's not necessary

____ 29. Lose concentration while thinking about other things I have to do

____ 30. Not enough time alone

____ 31. Feel compelled to be punctual

____ 32. Pressure related to deadlines

Scoring

Add your scores and find your rating below.

0–9	Low difficulty with time-related stressors
10–19	Moderate difficulty with time-related stressors
20 or more	High difficulty with time-related stressors

Now go back and underline the five most significant time-related stressors for you. Identify two concrete strategies you can take to help relieve each of these key stressors:

Stressor 1:_____

1._____

2._____

Stressor 2:_____

1._____

2._____

Stressor 3:_____

1._____

2._____

Stressor 4:_____

1._____

2._____

Stressor 5:_____

1._____

2._____

SOURCE: Adapted from *Stress Management for Wellness,* 3rd edition by W. Schafer. © 1996 Wadsworth, a part of Cengage Learning, Inc. Reproduced by permission. www.cengage.com/permissions.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 14

Relaxation Techniques: Progressive Muscle Relaxation and Imagery

Relaxation techniques can counteract the effects of chronic stress and can be used in stressful situations to help bring the body back to normal levels of functioning. Choose one of the two relaxation techniques described here. Practice it every day until it becomes natural to you, and then use it whenever you feel the need. If, after you've given it a good try, one technique doesn't seem to work well, try the other (see Chapter 2 in your text for descriptions of additional techniques).

General Instructions

Both of the following techniques use scripts that you (or a friend or family member with a soothing voice) can record. Playing the tape back will help you learn the technique. It is best to record your tape in a quiet room, reading the script slowly and carefully. Use a warm and encouraging voice and include pauses between each sentence and paragraph of the script. Your final tape should be about 15–20 minutes long.

When you are ready to use your tape, remember that these techniques will work best if you are in a comfortable position (sitting or lying down) in a place where you won't be disturbed. Dim the light and loosen any tight clothing so you can breathe deeply and relax completely.

Script for Progressive Muscle Relaxation

Take a slow, deep breath . . . and relax. Relax. . . . Let your worries and thoughts drift away. Breathe slowly in . . . and out. . . . Relax.

Gently begin to pay attention to your *left foot*. . . . Feel your *left foot*. . . . Slowly tighten all the muscles in your *left foot* . . . and hold it . . . and relax them. Feel the tension melting away. . . . Feel your *foot* relaxed, and heavy, and warm. . . .

Breathe deeply in . . . and relax. . . .

Now begin to pay attention to your *right foot*. . . . Feel it. . . . Slowly tighten all the muscles in your *right foot* . . . and hold it . . . and relax them. Feel the tension melting away. . . . Feel your *foot* relaxed, and heavy, and warm. . . .

Breathe deeply in . . . and relax. . . .

(Continue following the pattern above, substituting different areas of your body for the italicized terms: left calf, right calf, left thigh, right thigh, hips and buttocks, stomach, chest, back, left arm and hand, right arm and hand, neck and shoulders, throat, jaw, eyes, forehead.)

Slowly scan your whole body, and if you feel any tension, relax . . . and let it go. . . . Now your whole body is relaxed . . . and at ease . . . and at peace. . . . Enjoy your quiet breathing. . . . Breathe in . . . and hold it . . . and breathe out. . . . Now your muscles are relaxed. . . . Your whole body is relaxed . . . and calm . . . and at peace. . . .

Enjoy this calm, peaceful sensation of deep relaxation . . . as you breathe in . . . and out . . . and in . . . and out. . . . Feel how soft and relaxed your muscles are. . . . Enjoy this calm sensation. . . . This is what it feels like when your body is relaxed . . . and at peace. . . . Whenever you feel tense, you can return to this refreshing, calm state of relaxation. . . .

Breathe deeply . . . and relax. . . . Your body feels refreshed and energized. . . . Take one more deep breath in . . . and relax. . . . You feel refreshed and ready . . . ready to bring this relaxed, energized feeling back with you into your everyday life. . . .

One more deep breath and you're ready. . . . Open your eyes gently, and stretch. . . . Take a deep breath.

(over)

Script for Imagery

Relax. . . . Close your eyes. . . . Let your worries and thoughts drift away. You are breathing slowly in . . . and out. . . . Relax. . . . You are going to use your ability to visualize . . . to daydream . . . to make pictures in your mind's eye. . . . Let your worries and thoughts drift away. . . . Your imaging will be clearest when your mind is free of thoughts and worries and concerns. . . . If distracting thoughts or doubts about this process come into your mind, let them float away like small clouds in a blue sky. . . .

Relax. . . . You are breathing slowly in . . . and out. . . . Relax. . . . Imagine yourself someplace that you love . . . or where you'd like to be . . . somewhere outdoors that feels quiet and personal . . . a calm place, a quiet beach, or a wood, or a valley. . . . Take a deep breath, imagine the beautiful clear air . . . and the warmth of sunlight . . . and a cool breeze. . . .

Imagine yourself sitting down . . . and breathing deeply in . . . and out . . . so calm . . . and so peaceful. . . . Perhaps you can hear birds . . . or waves lapping on the sand . . . or a river running nearby. . . . Perhaps you can smell the flowers. . . . Take another deep breath . . . and relax. . . .

Look around you. . . . What do you see? This beautiful place . . . the calm weather . . . trees, perhaps . . . their leaves moving in the breeze . . . or the waves gently breaking . . . a few small clouds . . . a flight of geese high overhead . . . the deep blue of the sky . . . the rich browns and wonderful fresh greens of the earth. . . .

Imagine closing your eyes and just listening . . . feeling the peacefulness . . . the restfulness of the place. . . . You can imagine yourself lying down in a comfortable position . . . and letting go of your worries and tensions . . . and relaxing. . . . Imagine the warmth of the sun . . . and the cool breeze playing on your face . . . as you relax . . . and breathe quietly in . . . and out. . . .

Listen to the quiet sounds around you. . . . Feel the sun on your skin, warming you, soothing away all tensions and cares. . . . Feel the breeze playing on your skin. . . . This place is so restful, so full of peace. . . . Let the faint smells and sounds of this marvelous place gently relax you. . . .

And breathe in . . . and out. . . . You can hear water in the distance. . . . The weather is just perfect . . . as you relax . . . and breathe in . . . and out. . . . Your mind is still. . . . If you have any last thoughts or worries, watch them float away like small clouds in a calm, blue sky. . . . You are at peace. . . . You are completely at peace. . . .

Relax and enjoy the sunlight and the breeze. . . . Relax. . . . Breathe gently and deeply . . . and relax. . . . Your body is rested and at peace. . . . You are drawing strength and energy from the sunlight. . . . As you breathe in, the energy fills you. . . . Your lungs are filled with oxygen . . . nourishing and healing energy . . . and peace. . . . Your body feels refreshed and energized. . . .

Take one more deep breath in . . . and relax. . . . You feel refreshed and ready . . . ready to bring this relaxed, energized feeling back with you into your everyday life. . . . One more deep breath . . . and you're ready. . . . Open your eyes gently, and stretch. . . . Take a deep breath. . . .

Your Responses

Describe the technique you tried and how you felt before and after:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 15

Stress-Management Techniques

Part I. Lifestyle Stress Management

For each of the areas listed in the table below, describe your current lifestyle as it relates to stress management. For example, do you have enough social support? How are your exercise and nutrition habits? Is time management a problem for you? For each area, list two ways that you could change your current habits to help you manage your stress. Sample strategies might include calling a friend before a challenging class, taking a short walk before lunch, and buying and using a date book to track your time.

	Current lifestyle	**Lifestyle change #1**	**Lifestyle change #2**
Social support system			
Exercise habits			
Nutrition habits			
Time-management techniques			
Self-talk patterns			
Sleep habits			

(over)

Part II. Relaxation Techniques

Choose two relaxation techniques described in Chapter 2 (progressive relaxation, visualization, deep breathing, meditation, yoga, taijiquan, music therapy). If a taped recording is available for progressive relaxation or visualization, these techniques can be performed by your entire class as a group.

List the techniques you tried:

1. _____
2. _____

How did you feel before you tried these techniques?

_____

_____

_____

_____

What did you think, or how did you feel, as you performed each of the techniques you tried?

1. _____

_____

_____

2. _____

_____

_____

How did you feel after you tried these techniques?

_____

_____

_____

_____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 16

Social Support

Part I. Assessing Your Level of Social Support

To determine whether your social network measures up, check whether each of the following statements is true or false for you.

True	False	
_____	_____	1. If I needed an emergency loan of $100, there is someone I could get it from.
_____	_____	2. There is someone who takes pride in my accomplishments.
_____	_____	3. I often meet or talk with family or friends.
_____	_____	4. Most people I know think highly of me.
_____	_____	5. If I needed an early morning ride to the airport, there's no one I would feel comfortable asking to take me.
_____	_____	6. I feel there is no one with whom I can share my most private worries and fears.
_____	_____	7. Most of my friends are more successful making changes in their lives than I am.
_____	_____	8. I would have a hard time finding someone to go with me on a day trip to the beach or country.

Scoring

Add up the number of true answers to questions 1–4 and the number of false answers to questions 5–8. If your score is 4 or more, you should have enough support to protect your health. If your score is 3 or less, refer to your textbook for suggestions on how to build up your social network.

Part II. Social Support Profile

Learn more about your network of social support by completing a social support profile. For each type of support listed below, check or list the people who most often provide that type of support for you. Put an asterisk in the box if that person reciprocates by coming to you for the same type of support.

TYPE OF SUPPORT	**Emotional** Someone you can trust with your most intimate thoughts and fears	**Social** Someone with whom you can hang out and share life experiences	**Informational** Someone you can ask for advice on major decisions	**Practical** Someone who will help you out in a pinch
Partner				
Relative				
Friend				
Neighbor				
Coworker or boss				
Therapist or clergy				

(over)

INTERNET ACTIVITY

The Internet can be a valuable resource for building up your social support network. Think about your hobbies and areas of interest. With the Internet, you can get in touch with organizations and people who share your interests. For example, from Yahoo!'s recreation and sports listings (http://dir.yahoo.com/recreation/sports), snowboarders can learn about equipment and technique as well as venues and events. If you are interested in human rights, Amnesty International's home page (http://www.amnesty.org) can put you in touch with a local chapter of the organization. Whatever your interests, odds are that you can find applicable Web pages, bulletin boards, chat rooms, and other Internet resources.

Choose a topic, and use a search engine to locate online resources. Describe what you find: What sites are available? What sorts of information can you obtain? Are there opportunities for you to interact online with people who share your area of interest? Did you find any organizations or groups operating in your area?

Area of interest: _____

Resources located:

QUIZ SOURCE: Japenga, A. 1995. A family of friends. *Health,* November/December. Reprinted with permission. SUPPORT PROFILE SOURCE: Adapted from How supportive is your social circle? 1997. *Health,* April. Reprinted with permission.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 17

Sleep

How Sleepy Are You?

To determine how drowsy you are during waking hours, record how likely you are to doze off in each of the following situations, using this scale:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

____ 1. Sitting and reading

____ 2. Watching television

____ 3. Sitting passively in a public place (such as a theater or a meeting where you're not directly involved)

____ 4. Being a passenger in a car for an hour

____ 5. Lying down in the afternoon

____ 6. Sitting and talking to someone

____ 7. Sitting quietly after a lunch without alcohol

____ 8. Sitting behind the wheel of a car while stopped for a few minutes in traffic

____ TOTAL

Scoring:

11–16 You may not get enough sleep, or the quality of your sleep may be poor.

17 or more You may have a serious sleep disorder and may benefit from consulting a professional.

Strategies for Better Sleep

The following strategies can help you get a better night's sleep; check off any that you try:

____ 1. Go to bed at the same time every night (time: _____), and get up at the same time every morning (time: _____).

____ 2. Exercise daily, but not too close to bedtime.

____ 3. Don't use tobacco.

____ 4. Don't use caffeine in the late afternoon or evening.

____ 5. Don't drink alcohol after dinner.

____ 6. Eat a light snack before bedtime.

____ 7. Write out a list of worries or a to-do list for the following day; then allow your mind to tune out such worries and distractions.

____ 8. Don't eat, read, study, or watch television in bed.

____ 9. Relax before bedtime with a book, music, or some relaxation exercises; give yourself time to wind down from your day's activities.

____ 10. If you don't fall asleep in 15–20 minutes, get out of bed and do something monotonous until you feel sleepy. Do the same if you wake up and can't fall asleep again.

(over)

Sleep Log

To help track your sleep behavior, keep a log similar to the following for several weeks. Look for patterns or lifestyle behaviors, such as caffeine use, that may interfere with sleep.

Date _____

Time you first turned out the lights last night: _____

How long it took you to fall asleep: _____

Number of times you awakened during the night: _____

Time you woke up for the last time this morning: _____

Total number of hours you slept last night: _____

How well did you sleep last night? (circle)

Terrible night 1 2 3 4 5 Great night

How rested did you feel this morning? (circle)

Not at all rested 1 2 3 4 5 Very well rested

How would you rate your overall mood and functioning during the day? (circle)

Poor 1 2 3 4 5 Very good

Additional notes

Caffeine use: _____

Tobacco use: _____

Alcohol use: _____

Exercise: _____

Sleeping medications: _____

Naps: _____

Stress level: _____

Other: _____

INTERNET ACTIVITY

Adequate sleep is critical for stress management and overall wellness, but it is something that many college students fail to obtain. Visit one or more of the following sites or do a search to identify five strategies for getting an adequate amount of sleep. If lack of sleep or insomnia is a particular problem for you, consider completing the detailed sleep diary available at the Web site for the National Sleep Foundation.

American Academy of Sleep Medicine: http://www.aasmnet.org
National Institutes of Health: National Center for Sleep Disorders Research:
National Sleep Foundation: http://www.sleepfoundation.org
SleepNet: http://www.sleepnet.com
SleepQuest: http://www.sleepquest.com

Site visited (URL):

Strategies for adequate sleep (list five):

QUIZ SOURCE: Johns, M. W. 1991. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 14(6): 540–545. Copyright © 1991 American Academy of Sleep Medicine. Reproduced with permission of American Academy of Sleep Medicine via Copyright Clearance Center. SLEEP LOG SOURCE: Sobel, D. S., and R. Ornstein. 1996. *The Healthy Mind, Healthy Body Handbook*. Los Altos, Calif.: DRx. Reprinted by permission.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 18

Confide in Yourself Through Writing

Writing about emotional upheavals in our lives can improve physical and mental health. Although the scientific research surrounding the value of expressive writing is still in the early phases, there are some approaches to writing that have been found to be helpful. Keep in mind that there are probably a thousand ways to write that may be beneficial to you. Think of these as rough guidelines rather than truth. Indeed, in your own writing, experiment on your own and see what works best.

Getting Ready to Write

Find a time and place where you won't be disturbed. Ideally, pick a time at the end of your workday or before you go to bed. Promise yourself that you will write for a minimum of 15 minutes a day for at least 3 or 4 consecutive days. Once you begin writing, write continuously. Don't worry about spelling or grammar. If you run out of things to write about, just repeat what you have already written. You can write longhand or you can type on a computer. (Start on the reverse of this page, if that works for you.) If you are unable to write, you can also talk into a tape recorder. You can write about the same thing on all 3–4 days of writing or you can write about something different each day. It is entirely up to you.

What to Write About

- Something that you are thinking or worrying about too much.
- Something that you are dreaming about.
- Something that you feel is affecting your life in an unhealthy way.
- Something that you have been avoiding for days, weeks, or years.

Write about your deepest emotions and thoughts about the most upsetting experience in your life. Really let go and explore your feelings and thoughts about it. In your writing, you might tie this experience to your childhood, your relationship with your parents, people you have loved or love now, or even your career. How is this experience related to who you would like to become, who you have been in the past, or who you are now?

Many people have not had a single traumatic experience, but all of us have had major conflicts or stressors in our lives and you can write about them as well. You can write about the same issue every day or a series of different issues. Whatever you choose to write about, however, it is critical that you really let go and explore your very deepest emotions and thoughts.

Warning: Many people report that after writing, they sometimes feel somewhat sad or depressed. Like seeing a sad movie, this typically goes away in a couple of hours. If you find that you are getting extremely upset about a writing topic, simply stop writing or change topics.

What to Do With Your Writing Samples

The writing is for you and for you only. The purpose is for you to be completely honest with yourself. When writing, secretly plan to throw away your writing when you are finished. Whether you keep it or save it is really up to you. Some people keep their samples and edit them. That is, they gradually change their writing from day to day. Others simply keep them and return to them over and over again to see how they have changed. Other ideas: Burn them, erase them, shred them, flush them, tear them into little pieces and toss them into the ocean or let the wind take them away.

(over)

Start Your Journal

SOURCE: Pennebaker, J. W. 2000. (http://homepage.psy.utexas.edu/homepage/faculty/pennebaker/Home2000/writingandhealth.html; retrieved November 30, 2008). Reprinted by permission of James W. Pennebaker.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 19

Problem Solving

Do you frequently increase your stress level by stewing over problems, small and large? You can generate an action plan in just a few minutes by going through a formal process of problem solving.

State the problem in one or two sentences:

Identify the key causes of the problem:

List three possible solutions:

1. _____
2. _____
3. _____

List the consequences, good and bad, of each solution:

1. _____
   _____
2. _____
   _____
3. _____
   _____

(over)

Choose the solution that you think will work best for you:

Make a list of what you will need to do to carry out your decision. Designate a time for doing each item on your list.

After you have tried your solution, evaluate it. Was it entirely successful? What will you try differently next time?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 20

Maslow's Characteristics of a Self-Actualized Person

In the spaces given below, describe yourself in relation to each of Maslow's characteristics of a self-actualized person. How closely does the description fit you? Where would you like to make changes?

1. **Clear perception of reality and comfortable relations with it.** The self-actualized person judges others accurately and is capable of tolerating uncertainty and ambiguity.

2. **Acceptance of self and others.** Self-actualizers accept themselves as they are and are not defensive. They have little guilt, shame, or anxiety.

3. **Natural and spontaneous.** Self-actualizers are spontaneous in both thought and behavior.

4. **Focus on problems rather than self.** Self-actualizers focus on problems outside themselves; they are concerned with basic issues and eternal questions.

5. **Need privacy; tend to be detached.** Although self-actualizers enjoy others, they do not mind solitude and sometimes seek it.

6. **Autonomous.** Self-actualizers are relatively independent of their culture and environment, but they do not go against convention just for the sake of being different.

7. **Continued freshness of appreciation.** Self-actualizers are capable of fresh, spontaneous, and nonstereotyped appreciation of objects, events, and people. They appreciate the basic pleasures of life.

(over)

8. **Mystic experience.** Self-actualizers have had peak experiences or experiences in which they have attained transcendence.

9. **Social interest.** Self-actualizers have feelings of identification, sympathy, and affection for others.

10. **Interpersonal relations.** Self-actualizers do on occasion get angry, but they do not bear long-lasting grudges. Their relationships with others are few but are deep and meaningful.

11. **Democratic character structure.** Self-actualizers show respect for all people regardless of race, creed, income level, and so on.

12. **Discrimination between means and ends.** Self-actualizers are strongly ethical with definite moral standards. They do not confuse means with ends; they relate to ends rather than means.

13. **Sense of humor.** Self-actualizers have a sense of humor that is both philosophical and nonhostile.

14. **Creativeness.** Self-actualizers are original and inventive, expressive, perceptive, and spontaneous in everyday life. They are able to see things in new ways.

15. **Nonconformity.** Self-actualizers fit into society, but they are independent of it and do not blindly comply with all its demands. They are open to new experiences.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 21

Self-Exploration: Identity, Values, Experiences, Goals

Learn more about your inner world by answering the following questions.

Your Personal Identity

1. List the characteristics, attitudes, beliefs, interests, activities, and relationships that make up your personal identity. What adjectives best describe you? Circle the five that you think are most important to your self-concept.

2. What are your strong and weak points? List at least five of each.

Your Values

1. List the personality traits or characteristics that you most value—for example, friendly, patient, successful, outgoing, cooperative, loyal to family and friends. These can be characteristics of your own or of others.

2. List the activities or accomplishments that you most value—for example, making lots of money, getting good grades, spending time with friends, making your own decisions. These can be accomplishments of your own or of others, or goals you have for the future.

(over)

3. List the social ideals, customs, and institutions that you value—for example, education, equality, freedom of speech, tolerance for diverse opinions.

4. How well does your current lifestyle reflect your values? List two behaviors or recent incidents in which you acted in accordance with your values. List two behaviors or incidents in which you acted in ways that conflict with your values.

Your Accomplishments and Struggles

1. What has happened in your life that you are particularly proud of? Write about your key accomplishments, including your psychological triumphs—for example, times when things went even better than you expected, when you came through trials and tribulations even better off, when you felt powerful and glorious, when you maintained a wonderful friendship.

2. How have these successes shaped your life? How have they affected the way you think of yourself and your capabilities? How have they affected your goals and the things you strive for?

(over)

3. What difficult events or periods have you gone through? Write about any significant psychological insults and injuries you've sustained—for example, your losses, disappointments, traumas, or quieter periods of despair, hopelessness, or loneliness.

4. How have you survived these traumas? How did you strengthen and heal yourself? What are their lasting effects on you?

Your Emotional World

1. How did your family express the following when you were a child: love and affection, pride (in accomplishments), interest in one another, anger, sadness, and fear?

2. What is your own philosophy about expressing these feelings?

Who You Want to Become

1. Describe the person you want to become. Write a mission statement for your own life. What is the purpose of your life? What is its meaning? What are you trying to accomplish? What is your larger struggle?

(over)

2. What significant goals have you yet to realize? These can be creating something or having a particular experience.

3. What can you do to help reach these goals and become the person you want to become? What would you most like to change about yourself?

4. What do you want your life to be like in 5 years? In 10 years?

5. Write your own epitaph and obituary. How do you want people to think of your life and to remember you? What legacy would you like to leave when you die?

SOURCE: Adapted from Gottman, J.M., and Nan Silver. *The Seven Principles for Making Marriage Work*. Copyright © 2004 by John M. Gottman, Ph.D. and Nan Silver. Published by Crown Publishers, a division of Random House, Inc.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 22

Developing Spiritual Wellness

To develop spiritual wellness, it is important to take time out to think about what gives meaning and purpose to your life and what actions you can take to support the spiritual dimension of your life.

Look Inward

This week, spend some quiet time alone with your thoughts and feelings. Slow the pace of your day, remove your watch, turn your phone or pager off, and focus on your immediate experience. Try one of the following activities or develop another that is meaningful to you and that contributes to your sense of spiritual well-being.

- *Spend time in nature:* Experience continuity with the natural world by spending solitary time in a natural setting. Watch the sky (day or night), a sunrise, or a sunset; listen to waves on a shore or wind in the trees; feel the breeze on your face or raindrops on your skin; smell the grass, brush, trees, or flowers. Open all your senses to the beauty of nature.
- *Experience art, architecture, or music:* Spend time with a work of art or architecture or a piece of music. Choose one that will awaken your senses, engage your emotions, and challenge your understanding. Take a break and then repeat the experience to see how your responses change the second time.
- *Express your creativity:* Set aside time for a favorite activity, one that allows you to express your creative side. Sing, draw, paint, play a musical instrument, sculpt, build, dance, cook, garden—choose an activity in which you will be so engaged that you will lose track of time. Watch for feelings of joy and exhilaration.
- *Engage in a personal spiritual practice:* Pray, meditate, do yoga, chant. Choose a spiritual practice that is familiar to you or try one that is new. Tune out the outside world and turn your attention inward, focusing on the experience.

In the space below, describe the personal spiritual activity you tried and how it made you feel—both during the activity and after:

(over)

Reach Out

Spiritual wellness can be a bond among people and can promote values such as as altruism, forgiveness, and compassion. Try one of the following spiritual activities that involve reaching out to others.

- *Share writings that inspire you:* Find two writings that inspire, guide, and comfort you—passages from sacred works, poems, quotations from literature, songs. Share them with someone else by reading them aloud and explaining what they mean to you.
- *Practice kindness:* Spend a day practicing small acts of personal kindness for people you know as well as for strangers. Compliment a friend, send a card, let someone go ahead of you in line, pick up litter, do someone else's chores, help someone with packages, say please and thank you, smile.
- *Perform community service:* Foster a sense of community by becoming a volunteer. Find a local nonprofit group and offer your time and talent. Mentor a youth, work at a food bank, support a literacy project, help build low-cost housing, visit seniors in a nursing home. You can also work on national or international issues by writing letters to your elected representatives and other officials.

In the space below, describe the spiritual activity you performed and how it made you feel—both during the activity and after. Include details about the writings you chose or the acts of kindness or community service you performed.

Keep a Journal

One strategy for continuing on the path toward spiritual wellness is to keep a journal. Use a journal to record your thoughts, feelings, and experiences; to jot down quotes that engage you; to sketch pictures and write poetry about what is meaningful to you. Begin your spirituality journal today.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 23

The General Well-Being Scale

For each question, choose the answer that best describes how you have felt and how things have been going for you *during the past month*.

1. How have you been feeling in general?
   - 5 _____ In excellent spirits
   - 4 _____ In very good spirits
   - 3 _____ In good spirits mostly
   - 2 _____ I've been up and down in spirits a lot
   - 1 _____ In low spirits mostly
   - 0 _____ In very low spirits

2. Have you been bothered by nervousness or your "nerves"?
   - 0 _____ Extremely so—to the point where I could not work or take care of things
   - 1 _____ Very much so
   - 2 _____ Quite a bit
   - 3 _____ Some—enough to bother me
   - 4 _____ A little
   - 5 _____ Not at all

3. Have you been in firm control of your behavior, thoughts, emotions, or feelings?
   - 5 _____ Yes, definitely so
   - 4 _____ Yes, for the most part
   - 3 _____ Generally so
   - 2 _____ Not too well
   - 1 _____ No, and I am somewhat disturbed
   - 0 _____ No, and I am very disturbed

4. Have you felt so sad, discouraged, hopeless, or had so many problems that you wondered if anything was worthwhile?
   - 0 _____ Extremely so—to the point I have just about given up
   - 1 _____ Very much so
   - 2 _____ Quite a bit
   - 3 _____ Some—enough to bother me
   - 4 _____ A little bit
   - 5 _____ Not at all

(over)

5. Have you been under or felt you were under any strain, stress, or pressure?
   0 _____ Yes—almost more than I could bear
   1 _____ Yes—quite a bit of pressure
   2 _____ Yes—some, more than usual
   3 _____ Yes—some, but about usual
   4 _____ Yes—a little
   5 _____ Not at all

6. How happy, satisfied, or pleased have you been with your personal life?
   5 _____ Extremely happy—couldn't have been more satisfied or pleased
   4 _____ Very happy
   3 _____ Fairly happy
   2 _____ Satisfied—pleased
   1 _____ Somewhat dissatisfied
   0 _____ Very dissatisfied

7. Have you had reason to wonder if you were losing your mind or losing control over the way you act, talk, think, feel, or of your memory?
   5 _____ Not at all
   4 _____ Only a little
   3 _____ Some, but not enough to be concerned
   2 _____ Some, and I've been a little concerned
   1 _____ Some, and I am quite concerned
   0 _____ Much, and I'm very concerned

8. Have you been anxious, worried, or upset?
   0 _____ Extremely so—to the point of being sick, or almost sick
   1 _____ Very much so
   2 _____ Quite a bit
   3 _____ Some—enough to bother me
   4 _____ A little bit
   5 _____ Not at all

9. Have you been waking up fresh and rested?
   5 _____ Every day
   4 _____ Most every day
   3 _____ Fairly often
   2 _____ Less than half the time
   1 _____ Rarely
   0 _____ None of the time

(over)

10. Have you been bothered by any illness, bodily disorder, pain, or fears about your health?
    0 _____ All the time
    1 _____ Most of the time
    2 _____ A good bit of the time
    3 _____ Some of the time
    4 _____ A little of the time
    5 _____ None of the time

11. Has your daily life been full of things that are interesting to you?
    5 _____ All the time
    4 _____ Most of the time
    3 _____ A good bit of the time
    2 _____ Some of the time
    1 _____ A little of the time
    0 _____ None of the time

12. Have you felt downhearted and blue?
    0 _____ All the time
    1 _____ Most of the time
    2 _____ A good bit of the time
    3 _____ Some of the time
    4 _____ A little of the time
    5 _____ None of the time

13. Have you been feeling emotionally stable and sure of yourself?
    5 _____ All the time
    4 _____ Most of the time
    3 _____ A good bit of the time
    2 _____ Some of the time
    1 _____ A little of the time
    0 _____ None of the time

(over)

14. Have you felt tired, worn out, used-up, or exhausted?

    0 _____ All the time

    1 _____ Most of the time

    2 _____ A good bit of the time

    3 _____ Some of the time

    4 _____ A little of the time

    5 _____ None of the time

Circle the number that seems closest to how you have felt generally *during the past month*.

15. How concerned or worried about your health have you been?

Not concerned at all	10	8	6	4	2	0	**Very concerned**

16. How relaxed or tense have you been?

Very relaxed	10	8	6	4	2	0	**Very tense**

17. How much energy, pep, and vitality have you felt?

No energy at all, listless	0	2	4	6	8	10	**Very energetic, dynamic**

18. How depressed or cheerful have you been?

Very depressed	0	2	4	6	8	10	**Very cheerful**

Scoring

Add up all the points for the answers you have chosen, and find your score below.

81–110	Positive well-being
76–80	Low positive
71–75	Marginal
56–70	Stress problem
41–55	Distress
26–40	Serious
0–25	Severe

SOURCE: National Center for Health Statistics, General Well-Being Scale (GWBS).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 24

Self-Esteem Inventory

Read each of the following statements; check the "like me" column if it describes how you usually feel and the "unlike me" column if it does not describe how you usually feel.

Like me	Unlike me		
_____	_____	1.	I spend a lot of time daydreaming.
_____	_____	2.	I'm pretty sure of myself.
_____	_____	3.	I often wish I were someone else.
_____	_____	4.	I'm easy to like.
_____	_____	5.	My family and I have a lot of fun together.
_____	_____	6.	I never worry about anything.
_____	_____	7.	I find it very hard to talk in front of a group.
_____	_____	8.	I wish I were younger.
_____	_____	9.	There are lots of things about myself I'd change if I could.
_____	_____	10.	I can make up my mind without too much trouble.
_____	_____	11.	I'm a lot of fun to be with.
_____	_____	12.	I get upset easily at home.
_____	_____	13.	I always do the right thing.
_____	_____	14.	I'm proud of my work.
_____	_____	15.	Someone always has to tell me what to do.
_____	_____	16.	It takes me a long time to get used to anything new.
_____	_____	17.	I'm often sorry for the things I do.
_____	_____	18.	I'm popular with people my own age.
_____	_____	19.	My family usually considers my feelings.
_____	_____	20.	I'm never happy.
_____	_____	21.	I'm doing the best work that I can.

(over)

Like me	Unlike me	
_____	_____	22. I give in very easily.
_____	_____	23. I can usually take care of myself.
_____	_____	24. I'm pretty happy.
_____	_____	25. I would rather associate with people younger than me.
_____	_____	26. My family expects too much of me.
_____	_____	27. I like everyone I know.
_____	_____	28. I like to be called on when I am in a group.
_____	_____	29. I understand myself.
_____	_____	30. It's pretty tough to be me.
_____	_____	31. Things are all mixed up in my life.
_____	_____	32. People usually follow my ideas.
_____	_____	33. No one pays much attention to me at home.
_____	_____	34. I never get scolded.
_____	_____	35. I'm not doing as well at work as I'd like to.
_____	_____	36. I can make up my mind and stick to it.
_____	_____	37. I really don't like being a man/woman.
_____	_____	38. I have a low opinion of myself.
_____	_____	39. I don't like to be with other people.
_____	_____	40. There are many times when I'd like to leave home.
_____	_____	41. I'm never shy.
_____	_____	42. I often feel upset.
_____	_____	43. I often feel ashamed of myself.
_____	_____	44. I'm not as nice-looking as most people.
_____	_____	45. If I have something to say, I usually say it.

(over)

Like me	Unlike me	
_____	_____	46. People pick on me very often.
_____	_____	47. My family understands me.
_____	_____	48. I always tell the truth.
_____	_____	49. My employer or supervisor makes me feel I'm not good enough.
_____	_____	50. I don't care what happens to me.
_____	_____	51. I'm a failure.
_____	_____	52. I get upset easily when I am scolded.
_____	_____	53. Most people are better liked than I am.
_____	_____	54. I usually feel as if my family is pushing me.
_____	_____	55. I always know what to say to people.
_____	_____	56. I often get discouraged.
_____	_____	57. Things usually don't bother me.
_____	_____	58. I can't be depended on.

Scoring

The test has a built-in "lie scale" to help determine if you are trying too hard to appear to have high self-esteem. If you answered "like me" to three or more of the following items, retake the test with an eye toward being more realistic in your responses: 1, 6, 13, 20, 27, 34, 41, 48.

To calculate your score, add up the number of times your responses match those given below. To determine how your level of self-esteem compares to that of others, find the value closest to your score in the appropriate column of the table.

Like me: Items 2, 4, 5, 10, 11, 14, 18, 19, 21, 23, 24, 28, 29, 32, 36, 45, 47, 55, 57

Unlike me: Items 3, 7, 8, 9, 12, 15, 16, 17, 22, 25, 26, 30, 31, 33, 35, 37, 38, 39, 40, 42, 43, 44, 46, 49, 50, 51, 52, 53, 54, 56, 58

Men	Women	
33	32	Significantly below average
36	35	Somewhat below average
40	39	Average
44	43	Somewhat above average
47	46	Significantly above average

(over)

INTERNET ACTIVITY

Use the Internet to find out more about how to cope with challenges to emotional and psychological wellness; examples include achieving healthy self-esteem, developing an adult identity, dealing with anger or loneliness, maintaining honest and assertive communication, and developing realistic self-talk. Choose one such challenge that is important in your life, and find strategies for successful coping or further development. Use one of the sites listed below or do a search.

American Psychological Association HelpCenter: http://apahelpcenter.org
Go Ask Alice: http://www.goaskalice.columbia.edu
Student Counseling Virtual Pamphlet Collection: http://counseling.uchicago.edu/resources/virtualpamphlets

Topic chosen: _____

Site(s) visited:_____

Coping strategies identified (list at least three):

SOURCE: Adapted from Coopersmith, S. 1967. *The Antecedents of Self-Esteem.* New York: W. H. Freeman. Reprinted by permission of W. H. Freeman. © 1967 by W. H. Freeman and Company.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 25

How Assertive Are You?

For each statement, indicate how characteristic or descriptive it is for you by writing in the appropriate number.

+3 = very characteristic of me, extremely descriptive
+2 = rather characteristic of me, quite descriptive
+1 = somewhat characteristic of me, slightly descriptive
–1 = somewhat uncharacteristic of me, slightly nondescriptive
–2 = rather uncharacteristic of me, quite nondescriptive
–3 = very uncharacteristic of me, extremely nondescriptive

_____ 1. Most people seem to be more aggressive and assertive than I am.

_____ 2. I have hesitated to make or accept dates because of shyness.

_____ 3. When the food served at a restaurant is not done to my satisfaction, I complain about it to the waiter or waitress.

_____ 4. I am careful to avoid hurting other people's feelings, even when I feel that I have been injured.

_____ 5. If a salesman has gone to considerable trouble to show me merchandise that is not quite suitable, I have a difficult time saying no.

_____ 6. When I am asked to do something, I insist upon knowing why.

_____ 7. There are times when I look for a good, vigorous argument.

_____ 8. I strive to get ahead as well as most people in my position.

_____ 9. To be honest, people often take advantage of me.

_____ 10. I enjoy starting conversations with new acquaintances and strangers.

_____ 11. I often don't know what to say to attractive persons of the opposite sex.

_____ 12. I hesitate to make phone calls to business establishments and institutions.

_____ 13. I would rather apply for a job or for admission to a college by writing letters than by going through with personal interviews.

_____ 14. I find it embarrassing to return merchandise.

_____ 15. If a close and respected relative were annoying me, I would smother my feelings rather than express my annoyance.

_____ 16. I have avoided asking questions for fear of sounding stupid.

_____ 17. During an argument I am sometimes afraid that I will get so upset that I will shake all over.

_____ 18. If a famed and respected lecturer makes a statement that I think is incorrect, I will have the audience hear my point of view as well.

_____ 19. I avoid arguing over prices with clerks and salespeople.

(over)

_____ 20. When I have done something important or worthwhile, I manage to let others know about it.

_____ 21. I am open and frank about my feelings.

_____ 22. If someone has been spreading false and bad stories about me, I see that person as soon as possible to have a talk about it.

_____ 23. I often have a hard time saying no.

_____ 24. I tend to bottle up my emotions rather than make a scene.

_____ 25. I complain about poor service in a restaurant or elsewhere.

_____ 26. When I am given a compliment, I sometimes just don't know what to say.

_____ 27. If a couple near me in a theater or at a lecture were conversing rather loudly, I would ask them to be quiet or to take their conversation elsewhere.

_____ 28. Anyone attempting to push ahead of me in a line is in for a good battle.

_____ 29. I am quick to express an opinion.

_____ 30. There are times when I just can't say anything.

Scoring

Some of the items in this test are reverse scored, so you need to change the sign of your answer. For the items listed below, if you answered with a negative number, change the sign from a minus to a plus; if you answered with a positive number, change the sign from a plus to a minus.

1	5	12	15	19	26
2	9	13	16	23	30
4	11	14	17	24	

Next, total your scores, and find your rating on the table below. (You may find it easier to add up your positive and negative scores separately and then subtract the total of your negative scores from the total of your positive scores.)

–29	Significantly below average
–15	Somewhat below average
0	Average
+15	Somewhat above average
+29	Significantly above average

SOURCE: Rathus, S. A. 1973. A 30-item schedule for assessing assertive behavior. *Behavior Therapy* 4:398–406.
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Name _____ Section _____ Date _____

WELLNESS WORKSHEET 26

How Comfortable Are You in Social Situations?

The statements below are things you may have thought to yourself at some time before, during, or after a social interaction with someone you would like to get to know. Decide how frequently you might have been thinking a similar thought, and enter the appropriate number from the scale below. Please answer as honestly as possible.

1 = hardly ever had the thought
2 = rarely had the thought
3 = sometimes had the thought
4 = often had the thought
5 = very often had the thought

_____ 1. When I can't think of anything to say, I can feel myself getting very anxious.
_____ 2. I can usually talk to women/men pretty well.
_____ 3. I hope I don't make a fool of myself.
_____ 4. I'm beginning to feel more at ease.
_____ 5. I'm really afraid of what she'll/he'll think of me.
_____ 6. No worries, no fears, no anxieties.
_____ 7. I'm scared to death.
_____ 8. She/He probably won't be interested in me.
_____ 9. Maybe I can put her/him at ease by starting things going.
_____ 10. Instead of worrying, I can figure out how best to get to know her/him.
_____ 11. I'm not too comfortable meeting women/men, so things are bound to go wrong.
_____ 12. What the heck, the worst that can happen is that she/he won't go for me.
_____ 13. She/He may want to talk to me as much as I want to talk to her/him.
_____ 14. This will be a good opportunity.
_____ 15. If I blow this conversation, I'll really lose my confidence.
_____ 16. What I say will probably sound stupid.
_____ 17. What do I have to lose? It's worth a try.
_____ 18. This is an awkward situation, but I can handle it.
_____ 19. Wow—I don't want to do this.
_____ 20. It would crush me if she/he didn't respond to me.
_____ 21. I've just got to make a good impression on her/him, or I'll feel terrible.
_____ 22. You're such an inhibited idiot.
_____ 23. I'll probably bomb out anyway.

(over)

_____ 24. I can handle anything.

_____ 25. Even if things don't go well, it's no catastrophe.

_____ 26. I feel awkward and dumb; she's/he's bound to notice.

_____ 27. We probably have a lot in common.

_____ 28. Maybe we'll hit it off real well.

_____ 29. I wish I could leave and avoid the whole situation.

_____ 30. Ah! Throw caution to the wind.

Scoring

For the Positive Thoughts scale, add up your responses to the following questions:

2	4	6	9	10	12	13	14
17	18	24	25	27	28	30	

For the Negative Thoughts scale, add up your responses to the following questions:

1	3	5	7	8	11	15	16
19	20	21	22	23	26	29	

Find your scores on the table below. A high score on the Positive Thoughts scale indicates a high degree of comfort in social situations and a low degree of social anxiety. A high score on the Negative Thoughts scale indicates a high degree of social anxiety. For tips on overcoming social anxiety, refer to the Behavior Change Strategy in Chapter 3 of your text.

Positive Thoughts		**Negative Thoughts**		
Men	Women	Men	Women	
40	45	34	31	Significantly below average
43	48	39	34	Somewhat below average
47	52	44	38	Average
51	56	49	42	Somewhat above average
54	59	54	45	Significantly above average

SOURCE: Glass, C. R., et al. 1982. Cognitive assessment of social anxiety: Development and validation of a self-statement questionnaire. *Cognitive Therapy and Research* 6:37–55. Copyright © 1982 by Plenum Publishing Corporation. With kind permission of Springer Science and Business Media.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 27

Recognizing Signs of Depression and Bipolar Disorder

You should get evaluated by a professional if you've had five or more of the following symptoms for more than 2 weeks or if any of these symptoms cause such a big change that you can't keep up your usual routine.

When You're Depressed:

____ You feel sad or cry a lot, and it doesn't go away.

____ You feel guilty for no reason; you feel you're no good; you've lost your confidence.

____ Life seems meaningless, or you think nothing good is ever going to happen again.

____ You have a negative attitude a lot of the time, or it seems as if you have no feelings.

____ You don't feel like doing a lot of the things you used to like—music, sports, being with friends, going out, and so on—and you want to be left alone most of the time.

____ It's hard to make up your mind. You forget lots of things, and it's hard to concentrate.

____ You get irritated often. Little things make you lose your temper; you overreact.

____ Your sleep pattern changes. You start sleeping a lot more or you have trouble falling asleep at night; or you wake up really early most mornings and can't get back to sleep.

____ Your eating pattern changes. You've lost your appetite or you eat a lot more.

____ You feel restless and tired most of the time.

____ You think about death or feel as if you're dying or have thoughts about committing suicide.

When You're Manic:

____ You feel high as a kite . . . like you're "on top of the world."

____ You get unrealistic ideas about the great things you can do . . . things that you really can't do.

____ Thoughts go racing through your head, you jump from one subject to another, and you talk a lot.

____ You're a nonstop party, constantly running around.

____ You do too many wild or risky things—with driving, with spending money, with sex, and so on.

____ You're so "up" that you don't need much sleep.

____ You're rebellious or irritable and can't get along at home or school or with your friends.

If you are concerned about depression in yourself or a friend, or if you are thinking about hurting or killing yourself, talk to someone about it and get help immediately. There are many sources of help: a good friend; an academic or resident adviser; the staff at the student health or counseling center; a professor, coach, or adviser; a local suicide or emergency hotline (get the phone number from the operator or directory) or the 911 operator; or a hospital emergency room.

(over)

INTERNET ACTIVITY

Use the Internet to learn more about depression—its causes, symptoms, risks, and treatment. Visit one of the following sites or do a search to locate a different depression-related site.

American Psychiatric Association: http://www.psych.org
American Psychological Association: http://www.apa.org
Depression and Bipolar Support Alliance: http://www.dbsalliance.org
Depression Screening: http://www.depressionscreening.org
National Institute of Mental Health: http://www.nimh.nih.gov

Visit at least one site; describe the resources and information available about depression.

URL:_____

Description of site/information available:

What was the most surprising fact about depression that you learned from the site?

SOURCE: National Institute of Mental Health. 2008. *Depression* (http://www.nimh.nih.gov/health/topics/depression/index.shtml; retrieved January 23, 2011).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 29

How Capable Are You of Being Intimate?

Determine how closely each statement describes your feelings. Circle the number in the appropriate column.

	Strongly disagree	Mildly disagree	Agree and disagree equally	Mildly agree	Strongly agree
1. I like to share my feelings with others.	1	2	3	4	5
2. I like to feel close to other people.	1	2	3	4	5
3. I like to listen to other people talk about their feelings.	1	2	3	4	5
4. I am concerned with rejection in my expression of feelings to others.	5	4	3	2	1
5. I'm concerned with being dominated in a close relationship with another.	5	4	3	2	1
6. I'm often anxious about my own acceptance in a close relationship.	5	4	3	2	1
7. I'm concerned that I trust other people too much.	5	4	3	2	1
8. Expression of emotion makes me feel close to another person.	1	2	3	4	5
9. I do not want to express feelings that would hurt another person.	5	4	3	2	1
10. I am overly critical of people in a close relationship.	5	4	3	2	1
11. I want to feel close to people to whom I am attracted.	1	2	3	4	5
12. I tend to reveal my deepest feelings to other people.	1	2	3	4	5
13. I'm afraid to talk about my sexual feelings with a person in whom I'm very interested.	5	4	3	2	1
14. I want to be close to a person who is attracted to me.	1	2	3	4	5
15. I would not become too close because it involves conflict.	5	4	3	2	1
16. I seek out close relationships with people to whom I am attracted.	1	2	3	4	5

(over)

	Strongly disagree	Mildly disagree	Agree and disagree equally	Mildly agree	Strongly agree
17. When people become close, they tend not to listen to each other.	5	4	3	2	1
18. Intimate relationships bring me great satisfaction.	1	2	3	4	5
19. I search for close intimate relationships.	1	2	3	4	5
20. It is important to me to form close relationships.	1	2	3	4	5
21. I do not need to share my feelings and thoughts with others.	5	4	3	2	1
22. When I become very close to another, I am likely to see things that are hard for me to accept.	5	4	3	2	1
23. I tend to accept most things about people with whom I share a close relationship.	1	2	3	4	5
24. I defend my personal space so others do not come too close.	5	4	3	2	1
25. I tend to distrust people who are concerned with closeness and intimacy.	5	4	3	2	1
26. I have concerns about losing my individuality in close relationships.	5	4	3	2	1
27. I have concerns about giving up control if I enter into a really intimate relationship.	5	4	3	2	1
28. Being honest and open with another person makes me feel closer to that person.	1	2	3	4	5
29. If I were another person, I would be interested in getting to know me.	1	2	3	4	5
30. I only become close to people with whom I share common interests.	5	4	3	2	1
31. Revealing secrets about my sex life makes me feel close to others.	1	2	3	4	5
32. Generally, I can feel just as close to someone of the same sex as someone of the other sex.	1	2	3	4	5
33. When another person is physically attracted to me, I usually want to become more intimate.	1	2	3	4	5
34. I have difficulty being intimate with more than one person.	5	4	3	2	1

(over)

	Strongly disagree	Mildly disagree	Agree and disagree equally	Mildly agree	Strongly agree
35. Being open and intimate with another person usually makes me feel good.	1	2	3	4	5
36. I usually can see another person's point of view.	1	2	3	4	5
37. I want to be sure that I am in good control of myself before I attempt to become intimate with another person.	5	4	3	2	1
38. I resist intimacy.	5	4	3	2	1
39. Stories of interpersonal relationships tend to affect me.	1	2	3	4	5
40. Undressing with members of a group increases my feelings of intimacy.	5	4	3	2	1
41. I try to trust and be close to others.	1	2	3	4	5
42. I think that people who want to become intimate have hidden reasons for wanting closeness.	5	4	3	2	1
43. When I become intimate with another person, the possibility of my being manipulated is increased.	5	4	3	2	1
44. I am generally a secretive person.	5	4	3	2	1
45. I feel that sex and intimacy are the same, and one cannot exist without the other.	5	4	3	2	1
46. I can only be intimate in a physical relationship.	5	4	3	2	1
47. The demands placed on me by those with whom I have intimate relationships often inhibit my own satisfaction.	5	4	3	2	1
48. I would compromise to maintain an intimate relationship.	1	2	3	4	5
49. When I am physically attracted to another, I usually want to become intimate with the person.	1	2	3	4	5
50. I understand and accept that intimacy leads to bad feelings as well as good feelings.	1	2	3	4	5

(over)

Scoring

To calculate your total score, add up the items you circled. Find the score on the table below that is closest to your total score.

150	Significantly below average
161	Somewhat below average
172	Average
183	Somewhat above average
194	Significantly above average

SOURCE: Amidon, E., V. K. Kumar, and T. Treadwell. 1983. Measurement of intimacy attitudes: The intimacy attitude scale—revisited. *Journal of Personality Assessment,* 47(6), December: 635–639. © 1983 Society for Personality Assessment, Inc. Reprinted by permission of Taylor & Francis Group, www.informaworld.com.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 31

Love Maps

Part I. Love Maps Questionnaire

Emotionally intelligent couples have richly detailed "love maps"—they know about each other's history, major goals and beliefs, and day-to-day struggles. To assess the quality of your current love maps, answer each of the following questions with "true" or "false."

1. I can name my partner's best friends.
2. I can tell you what stresses my partner is currently facing.
3. I know the names of some of the people who have been irritating my partner lately.
4. I can tell you some of my partner's life dreams.
5. I am very familiar with my partner's religious beliefs and ideas.
6. I can tell you about my partner's basic philosophy of life.
7. I can list the relatives my partner likes the least.
8. I know my partner's favorite music.
9. I can list my partner's three favorite movies.
10. My partner is familiar with my current stresses.
11. I know the three most special times in my partner's life.
12. I can tell you the most stressful thing that happened to my partner as a child.
13. I can list my partner's major aspirations and hopes in life.
14. I know my partner's major current worries.
15. My partner knows who my friends are.
16. I know what my partner would want to do if he or she suddenly won the lottery.
17. I can tell you in detail my first impressions of my partner.
18. Periodically, I ask my partner about his or her world right now.
19. I feel that my partner knows me pretty well.
20. My partner is familiar with my hopes and aspirations.

Scoring: Give yourself one point for each "true" answer.

10 or above: This is an area of strength in your relationship. You have a fairly detailed map of your partner's everyday life, hopes, fears, and dreams. If you maintain this level of knowledge and understanding of each other, you'll be well equipped to handle any problem areas that crop up in your relationship.

Below 10: Your relationship could stand some improvement in this area. By taking the time to learn more about your partner now, you'll find your relationship becomes stronger.

Part II. Make Your Own Love Maps

If your current love map is inadequate or out of date, interview your partner to learn more about what is going on in his or her life. Just ask questions—don't judge or offer advice. Your goal is to listen and learn.

The cast of characters in my partner's life:

Friends:

Potential friends:

Rivals, competitors, "enemies":

(over)

Recent important events in my partner's life:

Upcoming events (What is my partner looking forward to? Dreading?):

My partner's current stresses:

My partner's current worries:

My partner's hopes and aspirations (For self? For others?):

SOURCE: Gottman, J.M., and N. Silver. 2004. *The Seven Principles for Making Marriage Work*. Copyright © 2004 by John Gottman, Ph.D., and Nan Silver. Used by permission of Crown Publishers, a division of Random House, Inc.; Weidenfeld and Nicolson, a division of The Orion Publishing Group; and the authors care of Brockman, Inc.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 32

Sternberg's Triangular Love Scale

Read each of the following statements, filling in the blank spaces with the name of one person you love or care for deeply. Rate your agreement with each statement according to the following scale, and enter the appropriate number between 1 and 9.

1	2	3	4	5	6	7	8	9
Not at all				Moderately				Extremely

_____ 1. I am actively supportive of _____'s well-being.

_____ 2. I have a warm relationship with _____.

_____ 3. I am able to count on _____ in times of need.

_____ 4. _____ is able to count on me in times of need.

_____ 5. I am willing to share myself and my possessions with _____.

_____ 6. I receive considerable emotional support from _____.

_____ 7. I give considerable emotional support to _____.

_____ 8. I communicate well with _____.

_____ 9. I value _____ greatly in my life.

_____ 10. I feel close to _____.

_____ 11. I have a comfortable relationship with _____.

_____ 12. I feel that I really understand _____.

_____ 13. I feel that _____ really understands me.

_____ 14. I feel that I can really trust _____.

_____ 15. I share deeply personal information about myself with _____.

_____ 16. Just seeing _____ excites me.

_____ 17. I find myself thinking about _____ frequently during the day.

_____ 18. My relationship with _____ is very romantic.

_____ 19. I find _____ to be very personally attractive.

_____ 20. I idealize _____.

_____ 21. I cannot imagine another person making me as happy as _____ does.

_____ 22. I would rather be with _____ than with anyone else.

_____ 23. There is nothing more important to me than my relationship with _____.

_____ 24. I especially like physical contact with _____.

_____ 25. There is something almost "magical" about my relationship with _____.

_____ 26. I adore _____.

(over)

_____ 27. I cannot imagine life without _____.

_____ 28. My relationship with _____ is passionate.

_____ 29. When I see romantic movies and read romantic books, I think of _____.

_____ 30. I fantasize about _____.

_____ 31. I know that I care about _____.

_____ 32. I am committed to maintaining my relationship with _____.

_____ 33. Because of my commitment to _____, I would not let other people come between us.

_____ 34. I have confidence in the stability of my relationship with _____.

_____ 35. I could not let anything get in the way of my commitment to _____.

_____ 36. I expect my love for _____ to last for the rest of my life.

_____ 37. I will always feel a strong responsibility for _____.

_____ 38. I view my commitment to _____ as a solid one.

_____ 39. I cannot imagine ending my relationship with _____.

_____ 40. I am certain of my love for _____.

_____ 41. I view my relationship with _____ as permanent.

_____ 42. I view my relationship with _____ as a good decision.

_____ 43. I feel a sense of responsibility toward _____.

_____ 44. I plan to continue my relationship with _____.

_____ 45. Even when _____ is hard to deal with, I remain committed to our relationship.

Scoring

Psychologist Robert Sternberg sees love as being composed of three components: intimacy, passion, and commitment. The first 15 items in the scale reflect intimacy, the second 15 measure passion, and the final 15 reflect commitment. Add up your scores for each group of 15 items. Find the scores closest to your three totals in the appropriate column below to determine the degree to which you experience each of these three components of love.

Intimacy (Items 1–15)	**Passion** (Items 16–30)	**Commitment** (Items 31–45)	
93	73	85	Significantly below average
102	85	96	Somewhat below average
111	98	108	Average
120	110	120	Somewhat above average
129	123	131	Significantly above average

According to Sternberg, high scores in all three components would indicate consummate love. However, uneven or low scores do not necessarily mean that a relationship is not strong: All relationships have ups and downs, and the nature of a relationship may change over time.

SOURCE: The Triangular Love Scale from *The Triangle of Love: Intimacy, Passion, Commitment,* by Robert Sternberg. Copyright © 1988 by Robert Sternberg. Reprinted by permission of the author.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 33

What's Your Gender Communications Quotient?

How much do you know about how men and women communicate with one another? The 20 items in this questionnaire are based on research conducted in classrooms, private homes, businesses, offices, hospitals—the places where people commonly work and socialize. The answers are at the end of this quiz.

	True	False
1. Men talk more than women.	_____	_____
2. Men are more likely to interrupt women than they are to interrupt other men.	_____	_____
3. There are approximately ten times as many sexual terms for males as females in the English language.	_____	_____
4. During conversations, women spend more time gazing at their partner than men do.	_____	_____
5. Nonverbal messages carry more weight than verbal messages.	_____	_____
6. Female managers communicate with more emotional openness and drama than male managers.	_____	_____
7. Men not only control the content of conversations, but they also work harder in keeping conversations going.	_____	_____
8. When people hear generic words such as "mankind" and "he," they respond inclusively, indicating that the terms apply to both sexes.	_____	_____
9. Women are more likely to touch others than men are.	_____	_____
10. In classroom communications, male students receive more reprimands and criticism than female students.	_____	_____
11. Women are more likely than men to disclose information on intimate personal concerns.	_____	_____
12. Female speakers are more animated in their conversational style than are male speakers.	_____	_____
13. Women use less personal space than men.	_____	_____
14. When a male speaks, he is listened to more carefully than a female speaker, even when she makes the identical presentation.	_____	_____
15. In general, women speak in a more tentative style than do men.	_____	_____

(over)

	True	False
16. Women are more likely to answer questions that are not addressed to them.	_____	_____
17. There is widespread sex segregation in schools, and it hinders effective classroom communication.	_____	_____
18. Female managers are seen by both male and female subordinates as better communicators than male managers.	_____	_____
19. In classroom communications, teachers are more likely to give verbal praise to females than to male students.	_____	_____
20. In general, men smile more often than women.	_____	_____

Answers: 1. T; 2. T; 3. F; 4. T; 5. T; 6–9. F; 10–15. T; 16. F; 17. T; 18. T; 19. F; 20. F

SOURCE: Questionnaire by Hazel J. Rozema, Associate Professor, Communication Department, University of Illinois at Springfield, and John W. Gray, Emeritus Professor, University of Arkansas at Little Rock. Reprinted by permission of Dr. Hazel J. Rozema.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 34

Rate Your Family's Strengths

This Family Strengths Inventory was developed by researchers who studied the strengths of over 3000 families. To assess your family (either the family you grew up in or the family you have formed as an adult), circle the number that best reflects how your family rates on each strength. A number 1 represents the lowest rating and a number 5 represents the highest.

	Low				High
1. Spending time together and doing things with each other	1	2	3	4	5
2. Commitment to each other	1	2	3	4	5
3. Good communication (talking with each other often, listening well, sharing feelings with each other)	1	2	3	4	5
4. Dealing with crises in a positive manner	1	2	3	4	5
5. Expressing appreciation to each other	1	2	3	4	5
6. Spiritual wellness	1	2	3	4	5
7. Closeness of relationship between spouses	1	2	3	4	5
8. Closeness of relationship between parents and children	1	2	3	4	5
9. Happiness of relationship between spouses	1	2	3	4	5
10. Happiness of relationship between parents and children	1	2	3	4	5
11. Extent to which spouses make each other feel good about themselves (self-confident, worthy, competent, and happy)	1	2	3	4	5
12. Extent to which parents help children feel good about themselves	1	2	3	4	5

Scoring Add the numbers you have circled. A score below 39 indicates below-average family strengths. Scores between 39 and 52 are in the average range. Scores above 53 indicate a strong family. Low scores on individual items identify areas that families can profitably spend time on. High scores are worthy of celebration but shouldn't lead to complacency. Like gardens, families need loving care to remain strong.

What do you think is your family's major strength? What do you like best about your family?

(over)

What about your family would you most like to change?

INTERNET ACTIVITY

Think about some of the characteristics of your family—your current family or the family you grew up in. Are there two parents? Do both parents work? What is the total family income? If there are young children, who acts as caregiver? If married, how old were the partners at the time of their marriage? Has either partner been divorced? What is the educational attainment of family members? Were all family members born in the United States? Does the family own a home? Choose two such characteristics and determine how your family compares to the rest of the U.S. population by visiting the U.S. Census Bureau Web site (http://www.census.gov). You can do a search at the Census Bureau Web site, but you may find it easier to begin by clicking on Subjects A to Z and viewing the alphabetical menu of topics. (Topics include children, education, family, foreign born, home ownership, households, income, living arrangements, and marital status.)

Family characteristic #1: _____

How your family compares to the U.S. population:

Family characteristic #2: _____

How your family compares to the U.S. population:

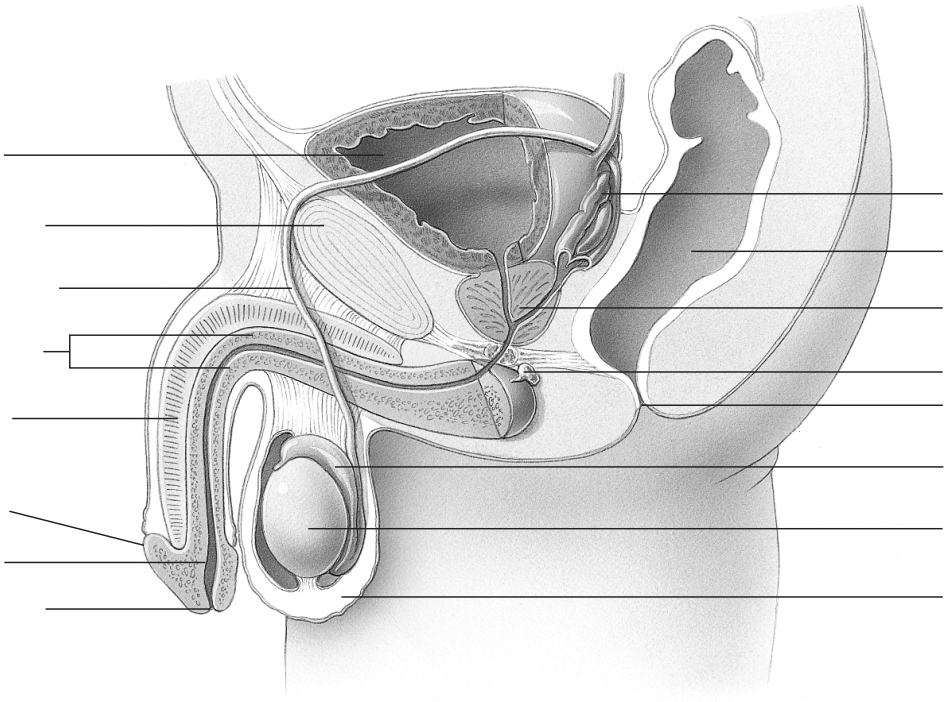
SOURCE: Stinnett, N., and J. DeFrain. 1986. *Secrets of Strong Families*. Copyright © 1986 by Nick Stinnett and John DeFrain. By permission of Little, Brown and Company. All rights reserved.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 35

Male and Female Reproductive Systems

Label the parts of the male and female reproductive systems.



(over)

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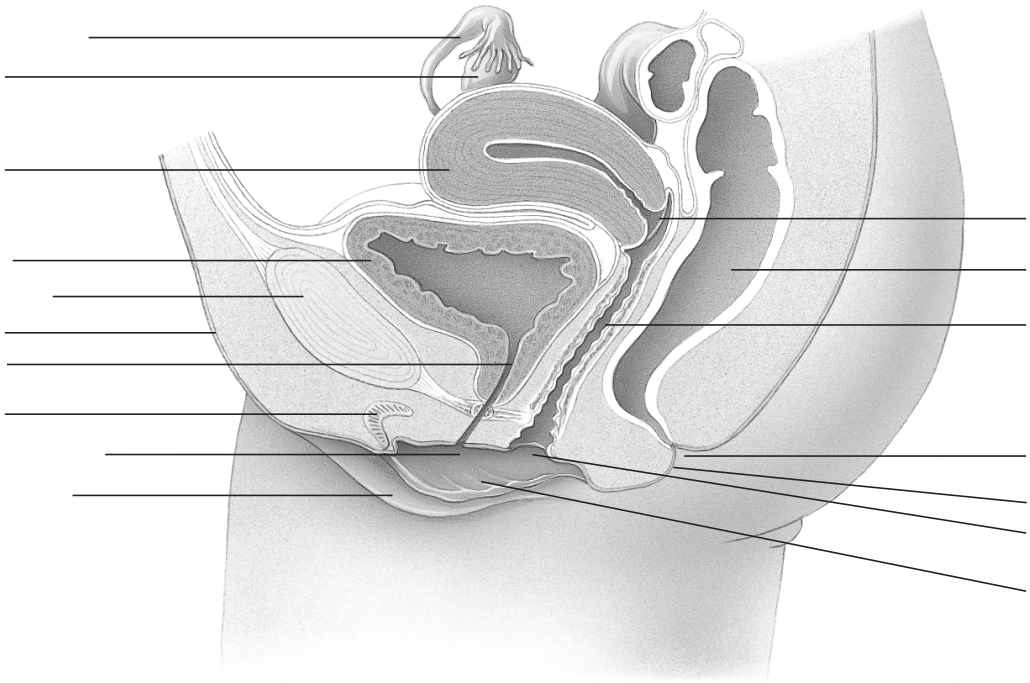


Name _____ Section _____ Date _____

WELLNESS WORKSHEET 36

Test Your Sexual Knowledge and Attitudes

Part I. Your Sexual Knowledge

When 2000 Americans were asked a series of questions about sexuality by the Kinsey Institute, only 45% of the respondents answered more than half the questions correctly. See how you do on this sample of true-or-false questions.

	T or F
1. The average American first has sexual intercourse at about 16 or 17 years of age.	_____
2. About 6 to 8 out of every 10 American women have masturbated.	_____
3. Most women have orgasms from penile thrusting alone.	_____
4. All men like large female breasts.	_____
5. People usually lose interest in sexual activities after age 60.	_____
6. Masturbation is physically harmful.	_____
7. The average length of a man's erect penis is 5 to 7 inches.	_____
8. Impotence usually cannot be treated successfully.	_____
9. Petroleum jelly, Vaseline Intensive Care, and baby oil are not good lubricants to use with a diaphragm or condom.	_____
10. Most women prefer a sexual partner who has a large penis.	_____
11. A woman cannot get pregnant if she has sex during her menstrual period.	_____
12. A woman cannot get pregnant if the man withdraws his penis before ejaculating.	_____

Answers: 1. T; 2. T; 3. F; 4. F; 5. F; 6. F; 7. T; 8. F; 9. T; 10. F; 11. F; 12. F

How well did you score? If you're not satisfied with your level of knowledge, consider checking your local library or bookstore for reputable self-help books about sexual functioning.

(over)

Part II. Your Sexual Attitudes

For each statement, circle the response that most closely reflects your position.

	Agree	Not sure	Disagree
1. Sex education encourages young people to have sex.	1	2	3
2. Homosexuality is a healthy, normal expression of sexuality.	3	2	1
3. Members of the other sex will think more highly of you if you remain mysterious.	1	2	3
4. It's better to wait until marriage to have sex.	1	2	3
5. Abortion should be a personal, private choice for a woman.	3	2	1
6. It's natural for men to have more sexual freedom than women.	1	2	3
7. Condoms should not be made available to teenagers.	1	2	3
8. Access to pornography should not be restricted for adults.	3	2	1
9. A woman who is raped usually does something to provoke it.	1	2	3
10. Contraception is the woman's responsibility.	1	2	3
11. Feminism has had a positive influence on society.	3	2	1
12. Masturbation is a healthy expression of sexuality.	3	2	1
13. I have many friends of the other sex.	3	2	1
14. Prostitution should be legalized.	3	2	1
15. Women use sex for love, men use love for sex.	1	2	3
16. Our society is too sexually permissive.	1	2	3
17. The man should be the undisputed head of the household.	1	2	3
18. Having sex just for pleasure is OK.	3	2	1

Scoring

Add up the numbers you circled to obtain your overall score. Find your score and rating below.

1–18	Traditional attitude about sexuality
19–36	Ambivalent or mixed attitude about sexuality
37–54	Open, progressive attitude about sexuality

PART I QUIZ SOURCE: Adapted from The Kinsey Institute/Roper Organization National Sex Knowledge Test from Reinisch, J. M., and R. Beasley. 1990. *The Kinsey Institute New Report on Sex.* New York: St. Martin's Press. Reprinted by permission of The Kinsey Institute for Research in Sex, Gender and Reproduction, Inc.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 37

Gender Roles

In the spaces provided below, list 10 characteristics and behaviors that you associate with being male and female in our society.

Male	Female
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____
8. _____	8. _____
9. _____	9. _____
10. _____	10. _____

Circle the numbers of 10 characteristics from the 20 that you feel best apply to yourself.
Did you choose any characteristics from your list for the other sex? If so, how many? _____

If you found most of the characteristics you chose for yourself were from your list for your own sex, are there any characteristics from the other list you wish you did have? Do you feel our society's definitions of gender roles are preventing you from behaving or developing in the ways you'd most like to?

(over)

If the characteristics you chose for yourself were a mix of both lists, what do you think your description of yourself indicates about the prevailing ideas about male and female characteristics you described for our society? How valid are they?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 38

Sexual Decision Making and Your Personal Life Plan

To learn more about your values and goals for the future, answer the following questions.

1. What are your religious, moral, and/or personal values regarding relationships and sex? When do you think it is right to start having sexual relationships—under what circumstances and with whom? Where do you think your ideas come from? Do you feel comfortable describing your values to others?

2. Would you like to be involved in a long-term relationship someday? If so, when? If you are currently involved in such a relationship, is it something that you always imagined you would have?

3. Do you want to have children? If so, when and how many? How would you feel if you found out you couldn't have children?

4. What are your major priorities and goals at this time? How would a sexual relationship fit in with these priorities and goals? Would it help you achieve your goals, detract from your efforts, or have no real effect?

(over)

5. What are the possible consequences—positive and negative—of being involved in a sexual relationship at this time? List the potential consequences to you in all areas of wellness, including such things as physical problems from STDs, emotional changes in a relationship, and financial costs of contraception. Do you feel ready to deal with all of the items on your list?

6. How would you feel if you or your partner became pregnant at this time? What outcome do you think you'd feel most comfortable with—continuing the pregnancy and raising the child, giving the child up for adoption, getting married, having an abortion? Do you feel emotionally and financially ready to be a parent?

7. How would you feel if you were exposed to a sexually transmitted disease? Would it affect how you think about yourself and/or your partner? Do you think you could take responsibility for obtaining proper treatment and informing partners?

8. How does your current sexual behavior fit in with your values and life plan? How does that make you feel? If you are currently acting in any way that is counter to your values or goals, consider why that is so? Have you just not thought about how your current behavior could affect your future? Or are you feeling pressure from yourself, your partner, or some other source?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 39

Facts About Contraception

To help you choose the best method of contraception for you and your partner, you must first be familiar with the different methods. Fill in the boxes below with the advantages and disadvantages of each method, along with how well each one protects against pregnancy and STDs. Use your text if necessary.

Method	Advantages	Disadvantages	Effectiveness/ STD protection
Oral contraceptives			
Contraceptive skin patch			
Vaginal contraceptive ring			
Contraceptive implants			
Injectable contraceptives			
Emergency contraception			
IUD			
Male condom			
Female condom			

(over)

WELLNESS WORKSHEET 39 — continued

Method	Advantages	Disadvantages	Effectiveness/ STD protection
Diaphragm with spermicide			
FemCap			
Contraceptive sponge			
Vaginal spermicides			
Abstinence			
Fertility awareness-based methods			
Withdrawal			
Male sterilization			
Female sterilization			

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 40

Which Contraceptive Method Is Right for You and Your Partner?

If you are sexually active, you need to use the contraceptive method that will work best for you. A number of factors may be involved in your decision. The following questions will help you sort out these factors and choose an appropriate method. Answer yes (Y) or no (N) for each statement as it applies to you and, if appropriate, your partner.

Y or N

_____ 1. I like sexual spontaneity and don't want to be bothered with contraception at the time of sexual intercourse.

_____ 2. I need a contraceptive immediately.

_____ 3. It is very important that I do not become pregnant now.

_____ 4. I want a contraceptive method that will protect me and my partner against STDs.

_____ 5. I prefer a contraceptive method that requires the cooperation and involvement of both partners.

_____ 6. I have sexual intercourse frequently.

_____ 7. I have sexual intercourse infrequently.

_____ 8. I am forgetful or have a variable daily routine.

_____ 9. I have more than one sexual partner.

_____ 10. I have heavy periods with cramps.

_____ 11. I prefer a method that requires little or no action or bother on my part.

_____ 12. I am a nursing mother.*

_____ 13. I want the option of conceiving immediately after discontinuing contraception.

_____ 14. I want a contraceptive method with few or no side effects.

If you answered "yes" to the numbers of statements listed on the left, the method on the right might be a good choice for you:

1, 3, 6, 10, 11, 12	Oral contraceptives
1, 3, 6, 8, 10, 11	Contraceptive patch, vaginal ring
1, 3, 6, 8, 10, 11, 12	Contraceptive injections
1, 3, 6, 8, 11, 12, 13	IUD
2, 4, 5, 7, 8, 9, 12, 13, 14	Condoms (male and female)
5, 7, 12, 13, 14	Diaphragm with spermicide and cervical cap
2, 5, 7, 8, 12, 13, 14	Vaginal spermicides and sponge
5, 7, 13, 14	Fertility awareness-based methods and withdrawal

*Progestin-only hormonal contraceptives (the minipill and Depo-Provera injections) are safe for use by nursing mothers; contraceptives that include estrogen are usually *not* recommended.

Your answers may indicate that more than one method would be appropriate for you. To help narrow your choices, circle the numbers of the statements that are *most* important for you. Before you make a final choice, talk with your partner(s) and your physician. Consider your own lifestyle and preferences as well as characteristics of each method (effectiveness, side effects, costs, and so on). For maximum protection against pregnancy and STDs, you might want to consider combining two methods.

(over)

INTERNET ACTIVITY

To help in your decision about contraception, research one of the methods that the quiz indicated would be appropriate for you and your partner. Alternatively, research a method that is currently under study or has only recently been approved. Visit one or more of the following sites, or do a search. (If you want further guidance in choosing a method, take the interactive contraception questionnaire located at the Web site for the Association of Reproductive Health Professionals: http://www.arhp.org.)

Ann Rose's Ultimate Birth Control Links Page: http://www.ultimatebirthcontrol.com
Family Health International: http://www.fhi.org
Managing Contraception: http://www.managingcontraception.com
Planned Parenthood Federation of America: http://www.plannedparenthood.org
Reproductive Health Online: http://www.reproline.jhu.edu

Contraceptive method to investigate: _____

Site visited (URL): _____

What new information about the method did you find?

Has what you've learned made you more or less likely to choose this method? Why?

What other useful information or materials does the site provide?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 41

Facts About Methods of Abortion

Familiarize yourself with the different methods of abortion by completing the chart below. Refer to your textbook if necessary.

Method	Description of procedure	Potential side effects	Time in pregnancy when used
Suction curettage			
Manual vacuum aspiration			
Dilation and evacuation			
Labor induction			

(over)

Method	Description of procedure	Potential side effects	Time in pregnancy when used
Medical abortion			

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 42

Your Position on the Legality and Morality of Abortion

To help define your own position on abortion, answer the following series of questions.

	Agree	Disagree
1. The fertilized egg is a human being from the moment of conception.	_____	_____
2. The rights of the fetus at any stage take precedence over any decision a woman might want to make regarding her pregnancy.	_____	_____
3. The rights of the fetus depend upon its gestational age: further along in the pregnancy, the fetus has more rights.	_____	_____
4. Each individual woman should have final say over decisions regarding her health and body; politicians should not be allowed to decide.	_____	_____
5. In cases of teenagers seeking an abortion, parental consent should be required.	_____	_____
6. In cases of married women seeking an abortion, spousal consent should be required.	_____	_____
7. In cases of late abortion, tests should be done to determine the viability of the fetus.	_____	_____
8. The federal government should provide public funding for abortion to ensure equal access to abortion for all women.	_____	_____
9. The federal government should not allow states to pass their own abortion laws; there should be uniform laws for the entire country.	_____	_____

10. Does a woman's right to choose whether or not to have an abortion depend upon the circumstances surrounding conception or the situation of the mother? In which of the following situations, if any, would you support a woman's right to choose to have an abortion? Check where appropriate.

    ____ An abortion is necessary to maintain the woman's life or health.

    ____ The pregnancy is a result of rape or incest.

    ____ A serious birth defect has been detected in the fetus.

    ____ The pregnancy is a result of the failure of a contraceptive method or device.

    ____ The pregnancy occurred when no contraceptive method was in use.

    ____ A single mother, pregnant for the fifth time, wants an abortion because she feels she cannot support another child.

    ____ A pregnant 15-year-old high school student feels having a child would be too great a disruption in her life and keep her from reaching her goals for the future.

    ____ A pregnant 19-year-old college student does not want to interrupt her education.

    ____ The father of the child has stated he will provide no support and is not interested in helping raise the child.

    ____ Parents of two boys wish to terminate the mother's pregnancy because the fetus is male rather than female.

(over)

On the basis of your answers to the questions on the previous page, write out your position on abortion. Should it be legal or illegal? Are there certain circumstances in which it should or should not be allowed? What sorts of rules should govern when it can be performed?

INTERNET ACTIVITY

To further develop your own position on abortion, review the materials at Web sites sponsored by a pro-life and a pro-choice group; use the sites listed in your text or do a search. Explore each site and note down here any arguments or points that you haven't previously considered.

URL of pro-life group sponsored site:_____
New arguments:

URL of pro-choice group sponsored site:_____
New arguments:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 43

Assessing Your Readiness to Become a Parent

Many factors have to be taken into account when you are considering parenthood. The following are some questions you should ask yourself and some issues you should consider when making this decision. Some issues are relevant to both men and women; others apply only to women. There are no "right" answers—you must decide for yourself what your answers reveal about your aptitude for parenthood.

Yes No

Physical Health

____ ____ 1. Are you in reasonably good health?

____ ____ 2. Do you have any behaviors or conditions that could be of special concern?

____ Obesity
____ Smoking
____ Alcohol and drug use
____ Hypertension
____ Previous problems with pregnancy or delivery
____ Anemia
____ Diabetes
____ Sexually transmitted diseases
____ Epilepsy
____ Prenatal exposure to diethylstilbestrol (DES)
____ Asthma

____ ____ 3. Are you under 20 or over 35 years of age?

____ ____ 4. Do you or your partner have a family history of a genetic problem that a baby might inherit?

____ Hemophilia
____ Sickle-cell disease
____ Down syndrome
____ Tay-Sachs disease
____ Phenylketonuria (PKU)
____ Cystic fibrosis
____ Thalassemia
____ Other

Financial Circumstances

____ ____ 1. Will your health insurance cover the costs of pregnancy, prenatal tests, delivery, and medical attention for the mother and baby before and after the birth?

____ ____ 2. Can you afford the supplies for the baby: diapers, bedding, crib, stroller, car seat, clothing, food, and medical supplies?

____ ____ 3. Will one parent leave his or her job to care for the baby?

____ ____ 4. If so, can the decrease in family income be worked into the family budget?

____ ____ 5. If both parents will continue to work, has affordable child care been set up?

____ ____ 6. The annual cost of raising a single child to age 17 is $11,000–$22,000 per year. Can you save and/or provide the necessary money?

Education, Career, and Child Care Plans

____ ____ 1. Have you completed as much of your education as you want?

____ ____ 2. Have you sufficiently established yourself in a career, if that is important to you?

____ ____ 3. Have you investigated parental leave and company-sponsored child care?

____ ____ 4. Do both parents agree on child care arrangements?

(over)

Yes No

Lifestyle and Social Support

____ ____ 1. Would you be willing to give up the freedom to do what you want to do when you want to do it?

____ ____ 2. Would you be willing to restrict your social life, to lose leisure time and privacy?

____ ____ 3. Would you and your partner be prepared to spend more time at home? Would you have enough time to spend with a child?

____ ____ 4. Are you prepared to be a single parent if your partner leaves or dies?

____ ____ 5. Do you have a network of family and friends who will help you with the baby? Are there community resources you can call on for additional assistance?

Readiness

____ ____ 1. Are you prepared to have a helpless being completely dependent on you 24 hours a day?

____ ____ 2. Do you like children? Have you enough experiences with babies, toddlers, and teenagers?

____ ____ 3. Do you think time spent with children is time well spent?

____ ____ 4. Do you communicate easily with others?

____ ____ 5. Do you have enough love to give a child? Can you express affection easily?

____ ____ 6. Do you feel good enough about yourself to respect and nurture others?

____ ____ 7. Do you have safe ways of handling anger, frustration, and impatience?

____ ____ 8. Would you be willing to devote a great part of your life, at least 18 years, to being responsible for a child?

Relationship with Partner

____ ____ 1. Does your partner want to have a child? Is he or she willing to ask these same questions of himself or herself?

____ ____ 2. Have you adequately discussed your reasons for wanting a child?

____ ____ 3. Does either of you have philosophical objections to adding to the world's population?

____ ____ 4. Have you and your partner discussed each other's feelings about religion, work, family, and child raising? Are your feelings compatible and conducive to good parenting?

____ ____ 5. Would both you and your partner contribute in raising the child?

____ ____ 6. Is your relationship stable? Could you provide a child with a really good home environment?

____ ____ 7. After having a child, would your partner and you be able to separate if you should have unsolvable problems? Or would you feel obligated to remain together for the sake of the child?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 44

Facts About Pregnancy and Childbirth

Review your knowledge of pregnancy and childbirth by answering the questions below. Refer to your textbook if necessary.

Conception

1. Trace the journey of the egg in a woman's body:

ovary → _____ → _____ → _____ (fertilized)

_____ (unfertilized)

How long does the egg's journey take? _____

2. Trace the journey of sperm cells from ejaculation to conception:

penis → _____ → _____ → _____ → _____

How does a sperm cell penetrate an egg? _____

_____

3. List three possible reasons for infertility in women:

a. _____

b. _____

c. _____

List two possible reasons for infertility in men:

a. _____

b. _____

4. List and define four treatments for infertility:

a. _____

b. _____

c. _____

d. _____

Pregnancy

1. List three early signs and symptoms of pregnancy:

a. _____

b. _____

c. _____

(over)

2. List specific changes that occur in the following during pregnancy:

   uterus: _____

   breasts: _____

   muscles and ligaments: _____

   pelvic joints: _____

   circulatory system: _____

   kidneys: _____

   body weight: _____

   emotions: _____

3. What are Braxton Hicks contractions? When do they occur and why?

   _____

   _____

4. List three characteristics of the fetus during each trimester. What systems have developed? How large is the fetus?

first trimester	second trimester	third trimester
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. List six important components of good prenatal care:

   a. _____ d. _____

   b. _____ e. _____

   c. _____ f. _____

Childbirth

What occurs during each of the three stages of labor? How long does each stage last?

first stage: _____

_____

second stage: _____

_____

third stage: _____

_____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 45

Creating a Detailed Family Health History and Tree

Knowing that a specific disease runs in your family allows you to watch closely for the early warning signs and get appropriate screening tests. It can also help you target important health habits to adopt. As described in Wellness Worksheet 8, you can put together a simple family health tree by compiling key facts on your primary relatives: siblings, parents, aunts and uncles, and grandparents. If possible, have your primary relatives fill out a family health history record like the one below.

Family Health History Form

Name: _____ Ethnicity: _____ Date of birth: _____

Blood and Rh type: _____ Occupation: _____

Please note any serious or chronic diseases you have experienced, with special attention to the following:

_____ Alcoholism
_____ Allergies
_____ Arthritis
_____ Asthma
_____ Blood diseases (hemophilia, sickle-cell disease, thalassemia, hemochromatosis)
_____ Cancer (breast, bowel, colon, ovarian, skin, stomach, etc.)
_____ Cystic fibrosis
_____ Diabetes
_____ Epilepsy
_____ Hearing impairment
_____ Heart defects or disease
_____ High blood cholesterol levels
_____ Huntington's disease
_____ Hypertension (high blood pressure)
_____ Learning disabilities (dyslexia, attention-deficit/hyperactivity disorder, autism)
_____ Liver disease
_____ Lupus
_____ Mental illness (bipolar disorder, schizophrenia)
_____ Mental retardation (Down syndrome, fragile X syndrome, etc.)
_____ Migraine headaches
_____ Miscarriages or neonatal deaths
_____ Multiple sclerosis
_____ Muscular dystrophy
_____ Myasthenia gravis
_____ Obesity
_____ Phenylketonuria (PKU)
_____ Recurrent or severe infections
_____ Respiratory disease (emphysema, chronic bronchitis)
_____ Rh disease
_____ Skin disorders
_____ Tay-Sachs disease
_____ Thyroid disorders
_____ Tuberculosis
_____ Visual disorders (dyslexia, glaucoma, retinitis pigmentosa)
_____ Other (please list):

(over)

List any of your lifestyle behaviors that may have health-related consequences (including tobacco use, dietary and exercise habits, and alcohol use):

Please note names of your relatives below, along with indications of any illnesses, such as those listed on the previous page, that affected them. If they are deceased, list age and cause. Also make note of their lifestyle habits such as smoking.

Father: _____

_____

_____

Mother:_____

_____

_____

Brothers and sisters:_____

_____

_____

Children of brothers and sisters: _____

_____

_____

If you don't have enough information on past generations, you can get clues by requesting death certificates from state health departments or medical records from relatives' physicians or hospitals where they died. Once you've collected the information you want, plug it into a tree format. (An online version of a family health tree is available at http://familyhistory.hhs.gov.)

SOURCE: Adapted from March of Dimes Birth Defects Foundation. 2001. *Genetic Counseling.* Copyright © March of Dimes Birth Defects Foundation, 2001. Reprinted with permission.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 46

Developing a Birth Plan

What type of birth experience would you and your partner prefer? Think about your preferences in each of the following areas. In addition to considering these questions on your own and with your partner, you would also need to discuss them with your physician or midwife.

1. Who will be present at the birth? The father? Friends? Children or other relatives?

2. What type of room would you like to be in for the birth?

3. What type of environment—music, lighting, furniture, and so on—would you prefer?

4. Who would you like to have "catch" the baby when he or she is born? Who will cut the umbilical cord?

5. Will the baby be fed by breast or bottle?

(over)

6. What types of routine medical tests and treatments may be performed? (These are questions that should be discussed with your physician or midwife.)

   - Can the mother eat or drink during labor?

   - Can the mother take a shower or bath during labor? Walk around?

   - Under what circumstances would drugs be used to induce or augment labor?

   - Is electronic fetal monitoring used?

   - Under what circumstances would an episiotomy be performed?

   - Under what circumstances would forceps or vacuum extraction be used?

   - What types of medications are typically used during labor and delivery?

   - Under what circumstances would a cesarean section be performed?

   - Can the baby spend the night in the mother's room rather than in the nursery?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 47

Addictive Behaviors

Part I. General Addictive Behavior Checklist

Choose an activity or a behavior in your life that you feel may be developing into an addiction. Ask yourself the following questions about it, and answer yes (Y) or no (N).

Activity/behavior: _____

_____ 1. Do you engage in the activity on a regular basis?

_____ 2. Have you engaged in the activity over a long period of time?

_____ 3. Do you currently engage in this activity more than you used to?

_____ 4. Do you find it difficult to stop or to avoid the activity?

_____ 5. Have you tried and failed to cut down on the amount of time you spend on the activity?

_____ 6. Do you turn down or skip social/recreational events in order to engage in the activity?

_____ 7. Does your participation in the activity interfere with your attendance and/or performance at school and/or work?

_____ 8. Have friends or family members spoken to you about the activity and indicated they think you have a problem?

_____ 9. Has your participation in the activity affected your reputation?

_____ 10. Have you lied to friends or family members about the amount of time, money, and other resources that you put into the activity?

_____ 11. Do you feel guilty about the resources that you put into the activity?

_____ 12. Do you engage in the activity when you are worried, frustrated, or stressed or when you have other painful feelings?

_____ 13. Do you feel better when you engage in the activity?

_____ 14. Do you often spend more time engaged in the activity than you plan to?

_____ 15. Do you have a strong urge to participate in the activity when you are away from it?

_____ 16. Do you spend a lot of time planning for your next opportunities to engage in the activity?

_____ 17. Are you often irritable and restless when you are away from the activity?

_____ 18. Do you use the activity as a reward for all other accomplishments?

(over)

Part II. Checklist for Drug Dependency

If you wonder whether you are becoming dependent on a drug, ask yourself the following questions. Answer yes (Y) or no (N).

_____ 1. Do you take the drug regularly?

_____ 2. Have you been taking the drug for a long time?

_____ 3. Do you always take the drug in certain situations or when you're with certain people?

_____ 4. Do you find it difficult to stop using the drug? Do you feel powerless to quit?

_____ 5. Have you tried repeatedly to cut down or control your use of the drug?

_____ 6. Do you need to take a larger dose of the drug in order to get the same high you're used to?

_____ 7. Do you feel specific symptoms if you cut back or stop using the drug?

_____ 8. Do you frequently take another psychoactive substance to relieve withdrawal symptoms?

_____ 9. Do you take the drug to feel "normal"?

_____ 10. Do you go to extreme lengths or put yourself in dangerous situations to get the drug?

_____ 11. Do you hide your drug use from others? Have you ever lied about what you're using or how much you use?

_____ 12. Do people close to you ask you about your drug use?

_____ 13. Are you spending more and more time with people who use the same drug as you?

_____ 14. Do you think about the drug when you're not high, figuring out ways to get it?

_____ 15. If you stop taking the drug, do you feel bad until you can take it again?

_____ 16. Does the drug interfere with your ability to study, work, or socialize?

_____ 17. Do you skip important school, work, social, or recreational activities in order to obtain or use the drug?

_____ 18. Do you continue to use the drug despite a physical or mental disorder or despite a significant problem that you know is worsened by drug use?

_____ 19. Have you developed a mental or physical condition or disorder because of prolonged drug use?

_____ 20. Have you done something dangerous or that you regret while under the influence of the drug?

Evaluation

On each of these checklists, the more times you answer yes, the more likely it is that you are developing an addiction. If your answers suggest abuse or dependency, talk to someone at your school health clinic or to your physician about taking care of the problem before it gets worse.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 48

Gambling Self-Assessment

Answer the following questions to help determine if gambling is affecting your life in a negative way.

Do You Need or Want to Change?

Yes	No	
___	___	1. Have you often gambled longer than you had planned?
___	___	2. Have you often gambled until your last dollar was gone?
___	___	3. Have thoughts of gambling caused you to lose sleep?
___	___	4. Have you used your income or savings to gamble while letting bills go unpaid?
___	___	5. Have you made repeated, unsuccessful attempts to stop gambling?
___	___	6. Have you broken the law or considered breaking the law to pay for your gambling?
___	___	7. Have you borrowed money to pay for your gambling?
___	___	8. Have you felt depressed or suicidal because of your gambling losses?
___	___	9. Have you been remorseful after gambling?
___	___	10. Have you ever gambled to get money to meet your financial obligations?

If you answered "yes" to any of these questions, then you may want to consider making a change.

Should You Examine Your Gambling Patterns More Closely?

Yes	No	
___	___	1. Have you ever tried to cut down on your gambling?
___	___	2. Are others annoyed by your gambling?
___	___	3. Do you ever gamble alone?
___	___	4. Do you ever feel guilty about your gambling?
___	___	5. Do you ever gamble to feel better?

If you answered "yes" to one or more questions, then you may want to consider looking at your gambling more closely.

Is Gambling Affecting Your Life?

Many people are not aware of all the ways that gambling can affect their lives. Answering these questions can alert you to problems that you might not have thought about before.

Yes	No	
___	___	1. Have you spent a great deal of your time during the past 12 months thinking of ways to get money for gambling?
___	___	2. During the past 12 months, have you placed bigger and bigger bets to experience excitement?
___	___	3. Did you find during the past 12 months that smaller bets are less exciting to you than before?

(over)

Yes	No	
___	___	4. Has stopping gambling or cutting down how much you gambled made you feel restless or irritable during the past 12 months?
___	___	5. Have you gambled during the past 12 months to make the uncomfortable feelings that come from stopping or reducing gambling go away?
___	___	6. Have you gambled to forget about stress during the past 12 months?
___	___	7. After losing money gambling, have you gambled to try to win back your lost money?
___	___	8. Have you lied to family members or others about how much you gambled during the past 12 months?
___	___	9. Have you done anything illegal during the past 12 months to get money to gamble?
___	___	10. During the past 12 months, have you lost or almost lost a significant relationship, job, or an educational or career opportunity because of your gambling?
___	___	11. Have you relied on others (e.g., family, friends, or work) to provide you with money to cover your gambling debts?
___	___	12. During the past 12 months have you tried to quit or limit your gambling, but couldn't?

These questions point out different problems you might have had because of gambling. Each question identifies a very serious problem. If you answered "yes" to one or more of these questions, you might want to think about reducing or stopping gambling.

Is Gambling Causing Money Problems?

Another way to understand your gambling is to consider the financial impact it has on you. Many problem gamblers experience various kinds of money problems. Answer the following questions to see if you have found yourself in some of the same money situations as problem gamblers:

Yes	No	
___	___	1. Have you ever been denied credit?
___	___	2. Have you ever taken money out of savings, investments, or retirement accounts to gamble?
___	___	3. Do you find yourself frequently bothered by bill collectors?
___	___	4. Have you ever used grocery money or other money for necessities to gamble?
___	___	5. Have you ever delayed paying household bills in order to get more money for gambling?
___	___	6. Have you ever taken cash advances from credit cards to use for gambling?

If you answered "yes" to any of these questions, it may be a sign that your gambling has affected your financial situation. Money problems, such as these, are usually symptoms, not the causes, of problem gambling.

What Next?

If your answers to the questions above indicate that you may have a problem with gambling, take steps to change your behavior. Try applying the behavior change concepts presented in Chapter 1, including examining the pros and cons of change, setting goals, and signing a contract. You may also consider professional counseling. The following Web sites have additional resources:

Gamblers Anonymous: http://www.gamblersanonymous.org

National Council on Problem Gambling: http://www.ncpgambling.org

Responsible Gambling Council: http://www.responsiblegambling.org

Your First Step to Change: http://www.masscompulsivegambling.org/paths/help_isa.php

SOURCE OF SELF-ASSESSMENT QUESTIONS: Massachusetts Council on Compulsive Gambling. 2003. *Your First Step to Change* (http://www.masscompulsivegambling.org/paths/help_isa.php; retrieved December 1, 2010).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 49

Reasons for Using or Not Using Drugs

If you have tried a psychoactive drug in the past, describe the circumstances of your first use of the drug. What were your reasons for trying the drug? Did other people have an effect on your decision to try the drug? Did you seek out the experience, or did you find yourself in a situation where the drug was available?

If you have continued to use a psychoactive drug, check which of the following reasons apply to you.

_____ 1. Taking drugs allows me to escape boredom or depression.

_____ 2. Drug use allows me to socialize with a group of people with whom I want to socialize.

_____ 3. Using drugs makes me feel daring.

_____ 4. Using drugs is exciting because they are illicit.

_____ 5. Drug use makes me feel better about myself.

_____ 6. Taking drugs allows me to alter my mood or see the world in a way I can't without the drugs.

_____ 7. Drug use is a natural part of my society.

_____ 8. I take drugs to rebel against my parents or society.

_____ 9. Drug use is enjoyable.

_____ 10. Drugs allow me to socialize more easily.

_____ 11. Drug use allows me to be a more spiritual person.

_____ 12. I take drugs when I am angry or upset.

List other reasons that apply to you:

(over)

If you have never tried a psychoactive drug, give your reasons for this choice:

If you have been in a situation where you were offered a psychoactive drug and turned it down, what reasons did you give? What would you say to someone who asked you why you were refusing the drug? Can you offer suggestions to someone who does not want to use psychoactive drugs but feels self-conscious about refusing them when they are offered?

INTERNET ACTIVITY

Use the Internet to find out more about a psychoactive drug that you've tried or been offered. Try one or more of the sites listed below or use a search engine to find other useful sites.

ClubDrugs.Gov: http://www.clubdrugs.gov
Do It Now Foundation: http://www.doitnow.org
Indiana Prevention Resource Center: http://www.drugs.indiana.edu
National Clearinghouse for Alcohol and Drug Information: http://ncadi.samhsa.gov
National Institute on Drug Abuse: http://www.nida.nih.gov; http://www.drugabuse.gov

Drug researched: _____

Site(s) visited (URL): _____

What new information did you find about the short- and long-term effects of the drug?

Write a brief description of the most helpful or interesting site you visited. What information and resources does the site provide?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 50

Facts About Psychoactive Drugs

Familiarize yourself with the different types of psychoactive drugs by filling in the blanks below; refer to your textbook as needed.

Opioids

Major drugs: _____

Routes of intake: _____

_____

Effects: _____

_____

_____

Special problems associated with use (overdose, tolerance, withdrawal, injuries, crime): _____

_____

_____

Central Nervous System Depressants

Major drugs: _____

Routes of intake: _____

_____

Effects: _____

_____

_____

Special problems associated with use (overdose, tolerance, withdrawal, injuries, crime): _____

_____

_____

Central Nervous System Stimulants

Major drugs: _____

Routes of intake: _____

_____

Effects: _____

_____

_____

Special problems associated with use (overdose, tolerance, withdrawal, injuries, crime): _____

_____

_____

(over)

Marijuana and Other Cannabis Products

Major drugs: _____

Routes of intake: _____

_____

Effects: _____

_____

_____

Special problems associated with use (overdose, tolerance, withdrawal, injuries, crime): _____

_____

_____

Hallucinogens

Major drugs: _____

Routes of intake: _____

_____

Effects: _____

_____

_____

Special problems associated with use (overdose, tolerance, withdrawal, injuries, crime): _____

_____

_____

Inhalants

Major drugs: _____

Routes of intake: _____

_____

Effects: _____

_____

_____

Special problems associated with use (overdose, tolerance, withdrawal, injuries, crime): _____

_____

_____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 51

Is Alcohol a Problem in Your Life?

Part I. Do You Have a Problem with Alcohol?

To determine if you may have a drinking problem, complete the following two screening tests.

A. CAGE Screening Test

Answer yes or no to the following questions:

Have you ever felt you should . . . . . Cut down on your drinking?
Have people . . . . . Annoyed you by criticizing your drinking?
Have you ever felt bad or . . . . . Guilty about your drinking?
Have you ever had an . . . . . Eye-opener (a drink first thing in the morning to steady your nerves or get rid of a hangover)?

One "yes" response suggests a possible alcohol problem. If you answered yes to more than one question, it is highly likely that a problem exists. In either case, it is important that you see your physician or other health care provider right away to discuss your responses to these questions.

B. AUDIT Screening Test

For each question, choose the answer that best describes your behavior. Then total your scores.

Questions	Points					Your Score
	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2–4 times a month	2–3 times a week	4 or more times a week	_____
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	_____
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	_____
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	_____
5. How often during the last year have you failed to do what was normally expected because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	_____
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	_____
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	_____
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	_____
9. Have you or has someone else been injured as a result of your drinking?	No	Yes, but not in the last year (2 points)		Yes, during the last year (4 points)		_____
10. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year (2 points)		Yes, during the last year (4 points)		_____
					Total	_____

A total score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption.

Even if you answered no to all four items in the CAGE screening test and scored below 8 on the AUDIT screening test, if you are encountering drinking-related problems with your academic performance, job, relationships, or health, or with the law, you should consider seeking help.

(over)

Part II. Are You Troubled by Someone Else's Drinking?

Millions of people are affected by the excessive drinking of someone close to them. The following checklist was created by Al-Anon to help people determine whether they are adversely affected by someone else's drinking. Check any statement that is true for you.

_____ 1. Do you worry about how much someone else drinks?

_____ 2. Do you have money problems because of someone else's drinking?

_____ 3. Do you tell lies to cover up for someone else's drinking?

_____ 4. Do you feel that if the drinker cared about you, he or she would stop drinking to please you?

_____ 5. Do you blame the drinker's behavior on his or her companions?

_____ 6. Are plans frequently upset or canceled or meals delayed because of the drinker?

_____ 7. Do you make threats, such as, "If you don't stop drinking, I'll leave you"?

_____ 8. Do you secretly try to smell the drinker's breath?

_____ 9. Are you afraid to upset someone for fear it will set off a drinking bout?

_____ 10. Have you been hurt or embarrassed by a drinker's behavior?

_____ 11. Are holidays and gatherings spoiled because of drinking?

_____ 12. Have you considered calling the police for help in fear of abuse?

_____ 13. Do you search for hidden alcohol?

_____ 14. Do you often ride in a car with a driver who has been drinking?

_____ 15. Have you refused social invitations out of fear or anxiety?

_____ 16. Do you feel like a failure because you can't control the drinker?

_____ 17. Do you think that if the drinker stopped drinking, your other problems would be solved?

_____ 18. Do you ever threaten to hurt yourself to scare the drinker?

_____ 19. Do you feel angry, confused, or depressed most of the time?

_____ 20. Do you feel there is no one who understands your problems?

If you answered yes to three or more of these questions, Al-Anon or Alateen may be able to help: http://www.al-anon.alateen.org.

SOURCES: Part I: A. CAGE test: National Institute on Alcohol Abuse and Alcoholism. 1996. *Alcoholism: Getting the Facts.* NIH Publication No. 96-4153. B. AUDIT test: Saunders, J. B., et al. 1993. Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption—II. *Addiction* 88:791–804, June. Reprinted by permission of Blackwell Publishing, Oxford, U.K. Part II: From *Are You Troubled By Someone's Drinking?* Copyright © 1980 by Al-Anon Family Group Headquarters, Inc. Reprinted by permission of Al-Anon Family Group Headquarters, Inc.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 52

Alcohol and How It Affects You

Evaluate Your Reasons for Drinking

Be honest with yourself. It is necessary for you to know why you drink in order to control your alcohol-related behavior. Put a check next to the statements that are true for you.

I drink to tune myself *in* to

____ enhance enjoyment of people, activities, special occasions

____ promote social ease by relaxing inhibitions, aiding ability to talk and relate to others

____ complement and add to enjoyment of food

____ relax after a period of hard work and/or tension

I drink to tune myself *out* to

____ escape problems

____ mask fears when courage and self-confidence are lacking

____ block out painful loneliness, self-doubt, feelings of inadequacy

____ substitute for close relationships, challenging activity

____ mask a sense of guilt about drinking

Alcohol Content

Drinks differ in the amount of pure alcohol they contain; therefore, a "drink" means different amounts of liquid depending on the type of drink. A proof value indicates concentration of alcohol in a particular drink; the proof value is equal to twice the percentage of alcohol in a drink. To calculate the number of ounces of pure alcohol in a drink, multiply the size of the drink by the percentage of alcohol it contains (one-half proof value). For example, a 12 oz beer (10 proof) has 0.6 oz of pure alcohol (10 proof = 5% alcohol concentration; 0.05×12 oz = 0.6 oz).

Calculate the number of ounces of pure alcohol in each of the following drinks.

Drink	Size (oz)	Proof value	Ounces of pure alcohol
beer	12	10	____
wine	6	24	____
sherry	4	40	____
liquor	1.5	80	____

Try the calculations on different size drinks and drinks of different alcohol content.

_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____
_____	_____	_____	____

(over)

Maintenance Rate (or how long to sip a drink)

Remember that the effects of alcohol will be greater when your BAC is rising than when you keep it stable or allow it to fall. BAC is directly proportional to the rate of ethyl alcohol intake. Assuming a general maintenance rate (rate at which the body rids itself of alcohol) of 0.1 oz of pure alcohol per hour per 50 pounds of body weight, you can calculate the approximate length of time it takes you to metabolize a given drink by applying the following formula:

$$\frac{2.5 \times \text{proof of drink} \times \text{volume (size in oz) of drink}}{\text{body weight}} = \text{time in hours per drink}$$

For example, to calculate how long it will take to metabolize one can (12 oz) of 10-proof beer for a person weighing 150 pounds:

$$\frac{2.5 \times 10 \times 12}{150} = 2 \text{ hours}$$

So, it takes this 150-pound individual 2 hours to completely metabolize one 12 oz can of 10-proof beer.

Choose your favorite three drinks (or choose three of the examples from the previous page), and use this formula to calculate your maintenance rate for each drink.

1. $\dfrac{(\quad) \times (\quad) \times (\quad)}{(\quad)} =$ ☐ hours/drink

2. $\dfrac{(\quad) \times (\quad) \times (\quad)}{(\quad)} =$ ☐ hours/drink

3. $\dfrac{(\quad) \times (\quad) \times (\quad)}{(\quad)} =$ ☐ hours/drink

In Case of Excess

To sober up, the only remedy that works is to stop drinking and allow time. For any given type of drink, the amount of time would be the number of drinks you have consumed multiplied by your maintenance rate for that drink. For the example given above, if the 150-pound individual had consumed three 12 oz cans of 10-proof beer, he or she would have to wait 6 hours before the alcohol would be metabolized. Calculate the amount of time that would have to elapse for you to metabolize all the alcohol if you had consumed three of one of the types of drinks you calculated a maintenance rate for above:

$3 \times (\quad) =$ _____ hours

Given this consumption level, your answer here indicates the number of hours you should wait before driving.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 53

Drinking and Driving

Protecting Yourself on the Road

List signs of an impaired driver:

List strategies for the following situations in which you encounter an impaired driver:

1. The driver is ahead of you:

2. The driver is behind you:

3. The driver is approaching you:

Being a Responsible Guest

List three strategies for drinking less in a social situation or for avoiding driving while impaired:

1. _____

2. _____

3. _____

Create a schedule or plan below for sharing designated driver responsibilities:

_____

_____

Being a Responsible Host

List three strategies for seeing that your guests do not leave your home or residence while impaired:

1. _____
2. _____
3. _____

(over)

List three things you might say or do for someone who is leaving your residence impaired and insists on driving home:

1. _____

2. _____

3. _____

INTERNET ACTIVITY

Part I. Drunk Driving Laws in Your State

Visit the site for the Insurance Institute for Highway Safety (http://www.iihs.org/laws/default.html) and find out about the drunk driving laws in your state. What is the BAC limit? What are the penalties?

Part II. Drinks to Reach Legal Limit

Visit one of the following sites, and determine the approximate number of drinks you would have to consume in an hour to be legally drunk in your state.

Facts on Tap: Blood Alcohol Level: http://www.factsontap.org/factsontap/students.htm
Intoximeters Drink Wheel Blood Alcohol Test: http://www.intox.com/wheel/drinkwheel.asp

Number of drinks:

Part III. Preventing Drunk Driving

Research strategies for preventing drunk driving—for drinking moderately, if at all, in social situations; for using designated drivers; and/or for being a responsible party host. Visit the sites listed below or those listed in your text, or use a search engine to locate other useful sites.

Facts on Tap: http://www.factsontap.org
Get the Keys: http://www.nhtsa.dot.gov/people/injury/alcohol/innocent/index.html
Go Ask Alice: http://www.goaskalice.columbia.edu
Higher Education Center for Alcohol and Other Drug Prevention: http://www.edc.org/hec
What's Driving You? http://www.whatsdrivingyou.org

Strategies:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 54

Could Alcohol Have Health Benefits for You?

Making general recommendations about alcohol and health is difficult because although there are some groups of people for whom light or moderate alcohol consumption may reduce the risk of coronary heart disease (CHD) and other chronic diseases, in other people, alcohol use is associated with serious adverse consequences. Experts agree that those who drink should limit alcohol use to no more than two drinks per day for men or one drink per day for women. (Heavy or binge use of alcohol under any circumstances is detrimental to health.) There is controversy, however, about whether there are any categories of current nondrinkers for whom beginning light alcohol consumption might be beneficial. The risks and benefits of light or moderate alcohol use depend on many individual factors, including personal and family health history. For people with certain characteristics or for anyone in certain situations, any consumption of alcohol is a potential health risk and should be avoided. Before turning to the decision charts about alcohol and health on the next page, complete the following checklist.

Personal Risk Factors Relating to Alcohol

Do you fall into a category that may indicate that any consumption of alcohol would be dangerous or illegal? Check any of the following that apply to you:

____ Under age 21

____ Family history of alcohol problems

____ Personal problems with alcohol or other drugs; past or present heavy alcohol use

____ Organ damage from alcohol use

____ Chronic liver disease, including hepatitis

____ Genetic risk of breast or ovarian cancer

____ Health condition worsened by alcohol use, including depression, uncontrolled high blood pressure, pancreatitis, and high triglycerides

____ Use of a medication, drug, or supplement that could potentially interact with alcohol (if unsure, check with your health care provider or pharmacist)

____ Pregnant or breastfeeding

____ For women: sexually active and not consistently using an effective contraceptive

____ Personal, moral, or religious beliefs that preclude alcohol use

A caution about dangerous situations: Regardless of health status, no amount of alcohol should be consumed before driving, operating machinery, or engaging in any activity that requires alertness.

Making Decisions About Light or Moderate Drinking

The charts on the following page were designed by two physicians to help individuals consider the personal risks and benefits of light or moderate alcohol use; they apply to most people who did *not* check any of the risk factors listed above. They are designed to be used in consultation with a health care provider, and *no increase in alcohol consumption should be considered without a professional evaluation.*

Interpreting the Charts

The following definitions are used in the charts:

Light/moderate drinking is up to one standard drink a day for women and up to two standard drinks a day for men.

Heavy drinking is three or more drinks a day for men and two or more drinks a day for women.

(over)

Coronary heart disease (CHD) risk factors:

- Family history of CHD (father or brother younger than 55 with CHD, mother or sister younger than 65 with CHD)
- Smoking
- High blood pressure
- Total cholesterol higher than 200
- HDL cholesterol lower than 35 (if HDL is higher than 60, subtract one risk factor)
- Age 40 or older for men, 50 or older for women

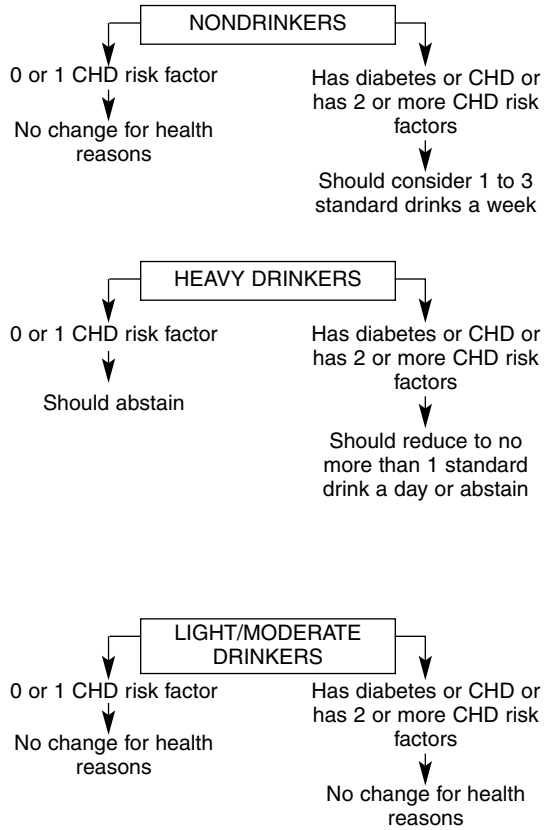
Note: Advice about alcohol use and CHD risk in no way reduces the importance of other risk factors. If you have any of the major controllable risk factors for CHD, *your most important health-related steps are to control those factors:* avoid tobacco, choose a healthy diet, engage in regular physical activity, achieve and maintain a healthy body weight, and work to control diabetes, high blood pressure, and high cholesterol.

Did you check any risk factors on the previous page? _____ yes _____ no. If yes, then no level of alcohol consumption is likely to have a health benefit for you. If no, find and circle the box on the following charts that applies to you. Compare the recommendation to your current level of alcohol use.

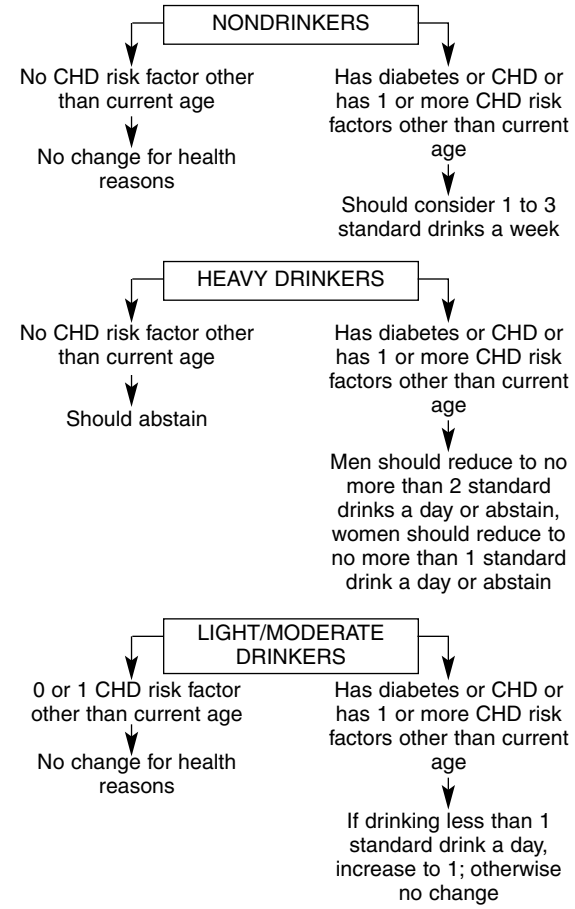
Current alcohol use: _____

Recommendation from chart: _____

Men Age 21 to 39 / Women Age 21 to 49



Men Age 40 and Older / Women Age 50 or Older



SOURCE OF CHARTS: Klatsky, A. L. 2003. Drink to your health? *Scientific American*, February. Copyright © 2003 by Scientific American, a division of Nature America, Inc. Reproduced with permission. All rights reserved.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 55

Nicotine Dependence: Are You Hooked?

Answer each question in the list below, giving yourself the appropriate points. Completing the smoking journal on the reverse may help you answer these questions more accurately.

____ 1. How soon after you wake up do you have your first cigarette?
   a. within 5 minutes (3)
   b. 6–30 minutes (2)
   c. 31–60 minutes (1)
   d. After 60 minutes (0)

____ 2. Do you find it difficult to refrain from smoking in places where it is forbidden, such as the library, theater, or a doctor's office?
   a. yes (1)
   b. no (0)

____ 3. Which cigarette would you most hate to give up?
   a. the first one in the morning (1)
   b. any other (0)

____ 4. How many cigarettes a day do you smoke?
   a. 10 or less (0)
   b. 11–20 (1)
   c. 21–30 (2)
   d. 31 or more (3)

____ 5. Do you smoke more frequently during the first hours after waking than during the rest of the day?
   a. yes (1)
   b. no (0)

____ 6. Do you smoke if you are so ill that you are in bed most of the day?
   a. yes (1)
   b. no (0)

____ Total

A total score of 7 or greater indicates that you are very dependent on nicotine and are likely to experience withdrawal symptoms when you stop smoking. A score of 6 or less indicates low to moderate dependence.

INTERNET ACTIVITY

Many Web sites offer help for smokers who want to quit. Visit one of the following or do a search to find another appropriate site. Write a brief description and evaluation of the quitting information offered. What information or advice is provided? Do you find it personally useful for quitting?

American Cancer Society: http://www.cancer.org
American Lung Association: http://www.lungusa.org
SmokeFree.Gov: http://www.smokefree.gov
Try to stop: http://www.makesmokinghistory.org

Site visited (URL): _____

Description:

(over)

Smoking Journal

Date _____ **Day** M TU W TH F SA SU

Time of day	N	R	Where were you?	What else were you doing?	Did someone else influence you?	Emotions and feelings?	Thoughts and concerns?

N = Number of cigarettes R = Rating (0–3) of how much you wanted cigarette

QUIZ SOURCE: Heatherton, T. F., et al. 1991. The Fagerstrom Test for Nicotine Dependence. A revision of the Fagerstrom Tolerance Questionnaire. *British Journal of Addictions* 86(9): 1119–1127.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 56

For Smokers Only: Why Do You Smoke?

Although smoking cigarettes is physiologically addicting, people smoke for reasons other than nicotine craving. What kind of smoker are you? Knowing what your motivations and satisfactions are can ultimately help you quit. This test is designed to provide you with a score on each of six factors that describe many people's smoking. Read the statements and then answer how *often* you feel this way when you smoke cigarettes. Be sure to answer each question.

	Always	Frequently	Occasionally	Seldom	Never
A. I smoke cigarettes in order to keep myself from slowing down.	5	4	3	2	1
B. Handling a cigarette is part of the enjoyment of smoking it.	5	4	3	2	1
C. Smoking cigarettes is pleasant and relaxing.	5	4	3	2	1
D. I light up a cigarette when I feel angry about something.	5	4	3	2	1
E. When I have run out of cigarettes, I find it almost unbearable until I can get them.	5	4	3	2	1
F. I smoke cigarettes automatically without even being aware of it.	5	4	3	2	1
G. I smoke cigarettes to stimulate me, to perk myself up.	5	4	3	2	1
H. Part of the enjoyment of smoking a cigarette comes from the steps I take to light up.	5	4	3	2	1
I. I find cigarettes pleasurable.	5	4	3	2	1
J. When I feel uncomfortable or upset about something, I light up a cigarette.	5	4	3	2	1
K. I am very much aware of the fact when I am not smoking a cigarette.	5	4	3	2	1
L. I light up a cigarette without realizing I still have one burning in the ashtray.	5	4	3	2	1
M. I smoke cigarettes to give me a "lift."	5	4	3	2	1
N. When I smoke a cigarette, part of the enjoyment is watching the smoke as I exhale it.	5	4	3	2	1
O. I want a cigarette most when I am comfortable and relaxed.	5	4	3	2	1
P. When I feel "blue" or want to take my mind off cares and worries, I smoke cigarettes.	5	4	3	2	1
Q. I get a real gnawing hunger for a cigarette when I haven't smoked for a while.	5	4	3	2	1
R. I've found a cigarette in my mouth and didn't remember putting it there.	5	4	3	2	1

How to Score

1. Enter the numbers you have circled to the smoking questions in the scoring chart, putting the number you have circled to question A over line A, to question B over line B, and so on.

(over)

2. Total the 3 scores on each line to get your totals. For example, the sum of your scores over lines A, G, and M gives you your score on *Stimulation;* lines B, H, and N give the score on *Handling;* and so on.

Scoring Chart

			Totals
A	G	M	Stimulation
B	H	N	Handling
C	I	O	Pleasurable relaxation
D	J	P	Crutch: tension reduction
E	K	Q	Craving: strong physiological or psychological addiction
F	L	R	Habit

What Your Scores Mean

Scores can vary from 3 to 15. Any score 11 and above is *high;* any score 7 and below is *low.* The higher your score, the more important a particular factor is in your smoking and the more useful the discussion of that factor can be in your attempt to quit.

Stimulation If you score high on this factor, it means that you are stimulated by cigarettes—you feel that they help wake you up, organize your energies, and keep you going. Try substituting a brisk walk or moderate exercise whenever you feel the urge to smoke.

Handling A high score suggests you gain satisfaction from handling a cigarette. Try doodling or toying with a pen, pencil, or other small object.

Accentuation of Pleasure—Pleasurable Relaxation A high score on this factor suggests that you receive pleasure from smoking. Try substituting other pleasant situations or events such as social or physical activities.

Reduction of Negative Feelings, or "Crutch" A high score on this factor means you use cigarettes as a kind of crutch in moments of stress or discomfort. Physical exertion or social activity may serve as useful substitutes for cigarettes. Refer back to Chapter 2 for other strategies for dealing with stress.

Craving or Strong Addiction A high score on this factor indicates that you have a strong psychological craving for cigarettes. "Cold turkey" is probably your best approach to quitting. It may be helpful for you to smoke more than usual for a day or two so that your taste for cigarettes is spoiled, and then isolate yourself completely from cigarettes until the craving is gone.

Habit A high score on this factor indicates that you smoke out of habit, not because smoking gives you satisfaction. Being aware of every cigarette you smoke and cutting down gradually may be effective quitting strategies for you.

Summary

Quitting smoking isn't easy. It usually means giving up something pleasurable that has a definite place in your life. In the end, of course, it's worth it. Now that you have some ideas about why you smoke, read the Behavior Change Strategy at the end of the chapter for a plan that will help you quit.

SOURCE: *Why Do You Smoke?* U.S. Department of Health and Human Services. Public Health Service. National Institutes of Health. NIH Pub. No. 90-1822.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 57

For Users of Spit Tobacco or Cigars

Part I. Spit Tobacco

If you use spit tobacco on a regular basis, it is highly likely that you are addicted to nicotine. To determine the strength of your addiction, check any of the following statements that are true for you.

_____ I no longer feel dizzy or nauseated as I did when I first used spit tobacco.

_____ I use spit tobacco more frequently and in more situations than I used to.

_____ I have changed products to ones that contain higher doses of nicotine (check product labels: the average dose of nicotine is 3.6 mg for snuff, 4.6 mg for chew, and 1.8 mg for cigarettes).

_____ I have my first dip or chew early in the day.

_____ I find it difficult to stop using spit tobacco for more than a few hours at a time.

_____ I have strong cravings for spit tobacco—when I don't use it, I think about it frequently.

_____ I use spit tobacco even when I'm ill, such as with a cold or the flu.

_____ I notice physical and emotional effects such as headache, irritability, fatigue, and difficulty sleeping or concentrating if I go longer than usual without using spit tobacco.

_____ I have tried and failed to quit.

_____ I also smoke cigarettes or cigars at least occasionally.

The more statements you checked, the stronger your dependence on nicotine. Find out more about how spit tobacco affects your life by completing the following:

How much spit tobacco do you use each day or week? How often do you use it?

When did you start using spit tobacco? Why did you start? How long do you plan to continue?

(over)

Carefully examine your mouth—inside and out—for signs of the effects of spit tobacco. Do you have any sores, white patches, or lumps; discolored or damaged teeth; gum recession; or bad breath? Note the size and location of any problems, and recheck your mouth regularly to track any changes.

Add up how much money you spend on spit tobacco: $_____ per week, $_____ per month, $_____ per year. Can you think of something else you'd like to spend this money on?

Ask your friends and family members what they think about your use of spit tobacco. Do they worry about its effect on your health? Do they find the associated bad breath and spitting to be unappealing? Do you get different responses to these questions from other users of spit tobacco than you do from nonusers?

Part II. Cigars

Describe your use of cigars: How often do you smoke a cigar? How many do you smoke per day, per week, or per month? What type of cigars do you smoke?

(over)

Do you smoke cigars more often now than in the past? Has there been any change in your pattern of use? Have you started using other forms of tobacco? (Any escalation of use could potentially be a sign of dependence on nicotine.)

Why do you smoke cigars? How does it make you feel physically, emotionally, and socially?

How much money do you currently spend on cigars each month? $ _____ What do you think about spending this much over a long period of time?

Ask your friends and family members what they think about your use of cigars. Do they worry about the health effects—on you and/or on the people around you when you smoke? Do they find the cigar smoke to be appealing or unappealing? Do you get different responses to these questions from other users of cigars than you do from nonusers?

Do you ever think about the health risk of cigar use—for yourself or those exposed to your tobacco smoke? Do you know what the health risks of cigar use are?

(over)

INTERNET ACTIVITY

Use the World Wide Web to obtain more information about the health effects of spit tobacco or cigars. Use the sites listed below or do a search. List five potential adverse effects of the use of spit tobacco or cigars; these can be adverse effects for the user or for nonusers exposed to her or his tobacco habit.

American Cancer Society: http://www.cancer.org
American Lung Association: http://www.lungusa.org
CDC Smoking and Tobacco Use: http://www.cdc.gov/tobacco
National Cancer Institute cigar information: http://cancercontrol.cancer.gov/tcrb/monographs/9
National Institute of Dental and Craniofacial Research: http://www.nidcr.nih.gov

Site(s) visited (URL):_____

Health effects:

1. _____
2. _____
3. _____
4. _____
5. _____

At the site(s) you visited, did you find any quitting resources that you can use? If so, provide a brief description.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 58

For Nonsmokers

List five things you might say to someone in asking him or her not to smoke in your presence. How would you defend your right to breathe smoke-free air?

1. _____

2. _____

3. _____

4. _____

5. _____

List three situations where you recall being exposed to cigarette smoking. For each, describe what you might have done to avoid the situation.

1. _____

2. _____

3. _____

If you've never smoked . . . Why do you think you never started smoking?

Did you have exposure to smokers (friends or family members) as you were growing up? How did this affect your decision not to smoke?

(over)

What kinds of things do you think make people start smoking?

If you're an ex-smoker . . . How and why did you quit?

Can you offer any advice for the smoker who wants to quit?

INTERNET ACTIVITY

The World Wide Web provides many opportunities to become more involved in health issues that confront the United States, including tobacco use. Research ways to become an online tobacco activist. Visit the Web sites listed below and/or do a search for additional tobacco-related sites.

Action on Smoking and Health: http://ash.org
American Lung Association Action network:
Campaign for Tobacco-Free Kids: http://www.tobaccofreekids.org
Tobacco BBS: http://tobacco.org

Site(s) visited (URL): _____

What opportunities for involvement did you discover? Do you think you are more likely to participate in online activist activities than activities that require personal contact? Why or why not?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 59

Analyzing Advertisements

You can become more aware of the power that advertising can have by critically evaluating an ad. Choose a print ad for some type of tobacco product and answer the following questions. (Under regulations proposed by the FDA, tobacco advertising may be severely restricted; if this occurs, complete this exercise using an ad for an alcoholic beverage.)

What is the verbal message of the ad? What does it say exactly? Are there direct references to the product?

Are certain words given unique treatment—larger or special type or a different color? Are there any plays on words or puns? How do these affect the message of the ad?

Are there any special offers or bargains such as savings coupons or merchandise offers?

How is the mandatory health warning handled in the ad?

What is the visual message of the ad? What images and symbols does it convey?

Is a famous person being used to sell the product? If so, how does this influence the effect the ad has on you?

(over)

Who appears in the ad? Do they reflect American society or the tobacco (or alcohol) users in our society in terms of gender, ethnicity, age, and socioeconomic status? Who do you think is being targeted by the ad?

What does the ad convey about the people who use the product—in terms of their characteristics or lifestyle? (Examples of messages might include fun, success, independence, popularity, slimness, rebellion, wealth, sophistication, and relaxation.) What does the ad seem to promise to users of tobacco (or alcohol)?

How is sexuality portrayed? Is sexuality being used in any way to sell the product?

Think of the ad as a story. What story does it tell?

What is left unsaid by the ad? Will using the product transform a tobacco (or alcohol) user's life in the ways the ad suggests? What effects aren't portrayed in the ad?

SOURCE: Adapted from Teays, W. 1996. *Second Thoughts: Critical Thinking from a Multicultural Perspective.* Mountain View, Calif.: Mayfield.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 60

Daily Food Record

The first step in evaluating your eating habits is to record your food choices and portion sizes. Use the chart below to record all the foods and beverages you consume during a typical day. (To learn even more about your eating habits, you may want to complete several copies of this food record and look at data for both weekdays and weekends.) Break down each food item into its components parts (for example, a turkey sandwich might be listed as sourdough bread, turkey, tomato, mayonnaise, and so on).

Complete the rest of the chart by listing the amount of each food you consumed in the appropriate column; the units—cups or ounce-equivalents—are listed at the top of the chart for each group and subgroup. For example, for your sandwich, you might enter 2 oz-eq in the "other" grains column for the bread, 3 oz-eq in the lean meat column for the turkey, 1/4 cup in the "other" vegetables column for the tomato, and so on. (To help you determine your portion sizes and the MyPyramid equivalents, refer to the table on the back of this worksheet.) It may be more difficult to determine amounts for oils, fats, and added sugars, but do the best you can. Remember, if you choose foods from any group that are not in their lowest-fat form or that contain any added sugars or fats, the extra calories should be entered as solid fats or added sugars under the discretionary calories heading. Once your day's record is complete, total up the amounts for each group.

	Grains		**Vegetables**									**Discretionary Calories**	
	Whole grains	Other	Dark green	Orange	Legumes	Starchy	Other	**Fruits**	**Milk**	**Lean meat and beans**	**Oils/trans-free**	***Solid fats***	***Added sugars***
Foods	oz-eq		cup					cup	cup	oz-eq	tsp	g	g/tsp
Daily Totals													

(over)

MyPyramid Group	Serving Sizes and Equivalents	Portion Sizes Guide
Grains	**1 oz equivalents =** • 1 slice of bread • 1 small muffin • 1 cup ready-to-eat cereal flakes • 1/2 cup cooked cereal, rice, grains, or pasta • 1 6-inch tortilla	• 1/2 cup of rice = an ice cream scoop or one-third of a soda can • 1 cup pasta = a small fist or a tennis ball • 1–2 oz muffin or roll = plum or large egg • 1 oz bagel = hockey puck or yo-yo • 1 tortilla = diameter of a small plate
Vegetable	**1/2 cup or equivalent (1 serving) =** • 1/2 cup raw or cooked vegetables • 1 cup raw leafy salad greens • 1/2 cup vegetable juice	• 1/2 cup cooked vegetables = an ice cream scoop or one-third of a soda can • 1/2 cup juice = one-third of a soda can • 1 medium potato = computer mouse The following count as 1 cup: 3 broccoli spears, 1 large tomato, 1 ear of corn, 12 baby carrots, 2 large celery stalks, 1 medium potato
Fruit	**1/2 cup or equivalent (1 serving) =** • 1/2 cup fresh, canned, or frozen fruit • 1/2 cup fruit juice • 1 small whole fruit • 1/4 cup dried fruit	• 1 medium fruit = baseball • 1/2 cup fruit = an ice cream scoop or one-third of a soda can • 1/2 cup juice = one-third of a soda can The following count as 1 cup: 1 large banana, 8 strawberries, 32 grapes, 12 melon balls, 1/4 medium cantaloupe
Milk	**1 cup or equivalent =** • 1 cup milk or yogurt • 1-1/2 oz natural cheese • 2 oz processed cheese	• 1 oz cheese = your thumb, 4 dice, or an ice cube
Lean Meat and Beans	**1 oz equivalents =** • 1 ounce cooked lean meat, poultry, or fish • 1/4 cup cooked dry beans or tofu • 1 egg • 1 tablespoon peanut butter • 1/2 ounce nuts or seeds	• 3 oz chicken or meat = deck of cards or an audiocassette tape • 1/2 cup cooked beans = an ice cream scoop or one-third of a soda can • 2 tablespoons peanut butter = a Ping-Pong ball or large marshmallow • 1/4 cup seeds = golf ball
Oils	**1 teaspoon or equivalent =** • 1 teaspoon vegetable oil or soft margarine • 1 tablespoon salad dressing or light mayonnaise	• 1 teaspoon margarine = tip of thumb

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 61

Portion Size Quiz and Worksheet

1. An ounce and a half of hard cheese—equivalent to 1 cup milk from the milk group—looks most like
   a. one domino.
   b. two dominoes.
   c. three dominoes.
2. A half cup of cooked pasta, considered an ounce equivalent from the grain group, most easily fits into
   a. an ice cream scoop (the kind with a release handle).
   b. a ball the size of a medium grapefruit.
   c. a cereal bowl.
3. One drink of wine roughly fills
   a. two-thirds of a coffee cup.
   b. one coffee cup.
   c. two coffee cups.
4. One 1/2-cup serving of green grapes consists of how many grapes?
   a. 10
   b. 15
   c. 20
5. Three ounces of beef most closely resembles
   a. a *TV Guide.*
   b. a regular bar of soap.
   c. a small bar of soap (as from a hotel).
6. One 1/2-cup serving of brussels sprouts consists of how many sprouts?
   a. 4
   b. 8
   c. 12
7. Two tablespoons of olive oil more or less fill
   a. a shot glass.
   b. a thimble.
   c. a Dixie cup.
8. Two tablespoons of peanut butter make a ball the size of
   a. a marble.
   b. a tennis ball.
   c. a Ping-Pong ball.
9. How many shakes of a five-hole salt shaker does it take to reach 1 teaspoon (approximately the maximum amount recommended per day)?
   a. 5
   b. 10
   c. 60
10. There are eight servings in a loaf of Entenmann's Raspberry Danish Twist. A serving is the width of
    a. one finger.
    b. two fingers.
    c. four fingers.

Answers

1. c	6. a
2. a	7. a
3. a	8. c
4. b	9. c
5. b	10. b

(over)

Review the following list of *actual* MyPyramid portion sizes and equivalents. For foods that you typically eat, write in your typical portion size and see how it compares. You may find that your typical portion size represents several servings.

BREAD, CEREAL, RICE, AND PASTA

Your Typical Portion Size	1 ounce-equivalents
	GENERALLY:
_____	1 slice of bread
_____	1/2 hamburger or hot dog bun
_____	1/2 English muffin or small (mini) bagel
_____	1 small roll, biscuit, or muffin (about 1 ounce each)
_____	1/2 cup cooked cereal
_____	1 cup ready-to-eat cereal flakes
_____	1/2 cup cooked pasta or rice
_____	5 to 7 small crackers (saltine size)
_____	2 to 3 large crackers (graham cracker square size)
	SPECIFICALLY:
_____	4-inch pita bread
_____	3 medium hard bread sticks, about 4-3/4 inches long
_____	9 animal crackers
_____	1/4 cup uncooked rolled oats
_____	2 tablespoons uncooked grits or Cream of Wheat cereal
_____	1 ounce uncooked pasta (1/4 cup macaroni or 3/4 cup noodles)
_____	3 tablespoons uncooked rice
_____	1 6-inch flour or corn tortilla
_____	2 small taco shells, corn
_____	1 4-inch pancake
_____	9 3-ring pretzels or 2 pretzel rods
_____	1 small piece corn bread
_____	4 small cookies
_____	1/2 medium doughnut
_____	1/2 large croissant
_____	3 rice or popcorn cakes
_____	3 cups popcorn

FRUITS

Your Typical Portion Size	MyPyramid Servings (1/2 cup equivalents)
	GENERALLY:
_____	a small whole fruit
_____	grapefruit half
_____	melon wedge (1 medium wedge or 1/8 of a medium melon)
_____	1/2 cup juice (100% juice)
_____	1/2 cup berries, cherries, or grapes
_____	1/2 cup cut-up fresh fruit
_____	1/2 cup cooked or canned fruit
_____	1/2 cup frozen fruit
_____	1/4 cup dried fruit
	SPECIFICALLY:
_____	1 small banana
_____	5 large strawberries
_____	50 blueberries
_____	30 raspberries
_____	11 cherries
_____	16 grapes
_____	1-1/2 medium plums
_____	1 small peach
_____	1 small orange
_____	2 medium apricots
_____	1 small avocado
_____	6 melon balls
_____	1/2 cup fruit salad, such as Waldorf
_____	1/2 medium mango
_____	1/4 medium papaya
_____	1 large kiwifruit
_____	4 canned apricot halves with liquid
_____	14 canned cherries with liquid
_____	1-1/2 canned peach halves with liquid
_____	2 canned pear halves with liquid
_____	2-1/2 canned pineapple slices with liquid
_____	3 canned plums with liquid
_____	9 dried apricot halves
_____	5 prunes
_____	1 snack container applesauce or mixed fruit

(over)

VEGETABLES

Your Typical Portion Size	MyPyramid Servings (1/2 cup equivalents)
	GENERALLY:
_____	1/2 cup cooked vegetables
_____	1/2 cup chopped raw vegetables
_____	1 cup leafy raw vegetables, such as lettuce or spinach
_____	1/2 cup tomato or spaghetti sauce
_____	1/4 cup tomato paste
_____	1/2 cup cooked dry beans (if not counted as a meat alternative)
	SPECIFICALLY:
_____	1/2 cup vegetable juice
_____	1 medium tomato or 5 cherry tomatoes
_____	1 medium carrot
_____	6 baby carrots
_____	1 large celery stalk
_____	1/3 medium cucumber
_____	10 medium whole young green onions
_____	8 green or red pepper rings
_____	13 medium radishes
_____	9 snow or sugar peas
_____	6 slices summer squash (yellow or zucchini)
_____	1 cup mixed green salad
_____	1/2 cup coleslaw or potato salad

Your Typical Portion Size	MyPyramid Servings (1/2 cup equivalents)
_____	1 or 2 spears broccoli
_____	1 medium whole green or red pepper
_____	1/3 summer squash (yellow and zucchini)
_____	1 globe artichoke
_____	6 asparagus spears
_____	2 whole beets, about 2 inches in diameter
_____	4 medium brussels sprouts
_____	1 small ear of corn
_____	7 medium mushrooms
_____	8 okra pods
_____	1 medium whole onion or 6 pearl onions
_____	1 medium whole turnip
_____	10 french fries
_____	1/2 baked potato, medium
_____	1/2 cup sweet potato
_____	1/3 acorn squash

(over)

MEAT, POULTRY, FISH, EGGS, DRY BEANS, AND NUTS

Your Typical Portion Size	1 ounce-equivalents
	GENERALLY:
_____	1 ounce cooked lean meat without bone
_____	1 ounce cooked poultry without skin or bone
_____	1 ounce cooked fish without bone
_____	1 ounce drained canned fish
_____	1 sandwich slice of turkey

(1 small steak is the equivalent to 3–4 ounces; 1 small lean hamburger, 2–3 ounces; 1 small chicken breast half, 3 ounces; 1 can tuna, 3–4 ounces; 1 salmon steak, 4–6 ounces; 1 small trout, 3 ounces)

	Meat alternatives
_____	1 egg (yolk and white)
_____	1/4 cup cooked dry beans (if not counted as a vegetable)
_____	1 tablespoon peanut butter
_____	1/2 ounce seeds or nuts (12 almonds, 7 walnut halves, 24 pistachios)
_____	1/4 cup baked beans
_____	1/2 cup bean soup
_____	1/4 cup tofu
_____	1 ounce tempeh
_____	1 falafel patty
_____	2 tablespoons hummus

MILK, CHEESE, AND YOGURT

Your Typical Portion Size	MyPyramid Servings (1 cup equivalents)
	GENERALLY:
_____	1 cup milk
_____	1 cup yogurt
_____	1 cup pudding
_____	1-1/2 ounces natural cheese
_____	2 ounces process cheese
_____	1/2 cup ricotta cheese
_____	2 cups cottage cheese

OILS

Your Typical Portion Size	1 teaspoon equivalents (4 grams)
_____	1 teaspoon vegetable oil
_____	1 teaspoon soft trans-free margarine
_____	1 tablespoon low-fat mayonnaise
_____	2 tablespoons light salad dressing
_____	8 large olives
_____	1/6 medium avocado
_____	1/2 tablespoon peanut butter
_____	1/3 ounce roasted nuts

SOURCES: Quiz from What's in a portion? 1994. *Tufts University Diet & Nutrition Letter*, September. Copyright 1994 by Tufts University Health & Nutrition Letter. Reproduced with permission of Tufts University Health & Nutrition Letter. *My Pyramid: Inside the Pyramid* (http://mypyramid.gov/pyramid; retrieved December 1, 2008); U.S. Department of Health and Human Services. 2005. *Dietary Guidelines for Americans,* 2005 (http://www.healthierus.gov/dietaryguidelines; retrieved December 1, 2008).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 62

Your Daily Diet Versus MyPyramid Recommendations

1. **Keep a food record:** Keep a record of everything you eat on a typical day (see Wellness Worksheet 60).
2. **Compare your intake to MyPyramid recommendations:** Complete the chart below using your food record. To determine the recommended number of servings for your calorie intake, refer to the MyPyramid chart in your text or visit MyPyramid.gov.

Food Group	Recommended Daily Amounts/Servings for Your Energy Intake	Your Actual Daily Intake (Amounts/Servings)	Serving Sizes and Equivalents
Grains *(total)*			1 oz equivalents = 1 slice of bread; 1 small muffin; 1 cup ready-to-eat cereal flakes; or 1/2 cup cooked cereal, rice, grains, pasta
Whole grains			
Other grains			
Vegetables *(total)*			1/2 cup or equivalent (1 serving) = 1/2 cup raw or cooked vegetables; 1 cup raw leafy salad greens; or 1/2 cup vegetable juice
*Dark-green**			
*Deep-yellow**			
*Legumes**			
*Starchy**			
*Other**			
Fruits			1/2 cup or equivalent (1 serving) = 1/2 cup fresh, canned, or frozen fruit; 1/2 cup fruit juice; 1 small whole fruit; or 1/4 cup dried fruit
Milk			1 cup or equivalent = 1 cup milk or yogurt; 1-1/2 oz natural cheese; or 2 oz processed cheese
Meat and beans			1 oz equivalents = 1 oz cooked lean meat, poultry, or fish; 1/4 cup cooked dry beans or tofu; 1 egg; 1 tablespoon peanut butter; or 1/2 oz nuts or seeds
Oils			1 teaspoon or equivalent = 1 teaspoon vegetable oil or soft margarine; 1 tablespoon salad dressing or light mayonnaise
Solid fats			
Added sugars			

* Compare your daily intake with the approximate daily intake derived from the weekly pattern given in MyPyramid.

It may be difficult to track values for added sugars and, especially, oils and fats, but be as accurate as you can. Check food labels for information on fat and sugar. (Note: For a more complete and accurate analysis of your diet, keep food records for 3 days and then average the results.)

(over)

3. **Further evaluate your food choices within the groups:** Based on the data you collected and what you learned in the chapter, what were the especially healthy choices you made (for example, whole grains and citrus fruits) and what were your less healthy choices? Identify the foods in the latter category by putting a checkmark next to them on your food record; these are areas where you can make changes to improve your diet. In particular, you may want to limit your intake of the following: processed, sweetened grains; high-fat meats and poultry skin; deep-fried fast foods; full-fat dairy products; regular sodas, sweetened teas, fruit drinks; alcohol beverages; other foods that primarily provide sugar and fat and few other nutrients. A significant proportion of the calories from these foods would be counted toward the discretionary calorie allowance for your level of energy intake; cutting back on these foods can help make room for greater amounts of healthier choices, including fruits, vegetables, and whole grains.
4. **Make healthy changes:** Bring your diet in line with MyPyramid by adding servings of food groups and subgroups for which you fall short of the recommendations. To maintain a healthy weight, you may need to balance these additions with reductions in other areas—by eliminating some of the fats, oils, sweets, and alcohol you consume, by cutting extra servings from food groups for which your intake is more than adequate; or by making healthier choices within the food groups. Make a list of foods to add and a list of foods to limit or eliminate:

Foods to add:	*Foods to limit or eliminate:*
_____	_____
_____	_____
_____	_____
_____	_____

INTERNET ACTIVITY

Find out how your eating habits compare with the Dietary Guidelines, MyPyramid, and recommended nutrient intakes by using the interactive MyPyramid Tracker at www.mypyramid.gov. Enter your food intake for one day, and evaluate it against the various guidelines:

(1) Dietary Guidelines recommendations:
Dietary components needing attention (not rated with a happy face):

Three tips for improving your intake of one of the components (click on the face):

(2) MyPyramid recommendations: For what groups does your day's food intake fall above or below your recommended intake? List two strategies for bringing your intake in line with MyPyramid:

(3) Nutrient intake: List nutrients for which your intake doesn't meet the recommendation or fall within the acceptable range:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 63

Putting MyPyramid Into Action: Healthier Choices Within Food Groups

Look over the following lists of examples for each of the food groups. These lists are broken into subgroups to emphasize foods that are particularly good sources of dietary fiber or of certain vitamins and minerals that are low in the diets of many Americans; food items with more fat and sugar are also identified. Hints for making healthy choices within each food group are provided.

For each food group, complete the following:

1. Circle the items you eat most often. If a food you commonly eat doesn't appear on the list, add it to the appropriate group and subgroup and then circle it.
2. Review the circled items, and analyze your current diet. Do your typical food choices conform to the recommendations in the hints section? Do you eat a variety of foods within each group?
3. Based on your analysis of your current diet, and with the goal of eating a variety of healthy foods, choose 3–6 items in each food group either to try for the first time or to eat more often. Choose food items that conform to the advice in the hints section and that are available and affordable.

FRUITS

Citrus, Melons, Berries

Blueberries	Honeydew melon	Strawberries
Cantaloupe	Kiwifruit	Tangerine
Citrus juices	Lemon	Ugli fruit
Cranberries	Orange	Watermelon
Grapefruit	Raspberries	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Fruits

Apple	Guava	Pineapple
Apricot	Grapes	Plantain
Asian pear	Mango	Plum
Banana	Nectarine	Prickly pear
Cherries	Papaya	Prunes
Dates	Passion fruit	Raisins
Figs	Peach	Rhubarb
Fruit juices	Pear	Star fruit
_____	_____	_____

Hints:

- Citrus fruits, melons, and berries are particularly good choices.
- Choose whole fruits more often than juices; choose fruit juices over fruit punches, ades, and drinks.
- For canned fruits, choose those packed in 100% fruit juice rather than in syrup.

Foods to try or emphasize:

_____ _____ _____

_____ _____ _____

_____ _____ _____

(over)

VEGETABLES

Dark-Green Leafy

Beet greens
Broccoli
Chard
Chicory
Collard greens
Dandelion greens
Endive
Escarole
Kale
Mustard greens
Romaine lettuce
Spinach
Turnip greens
Watercress

Orange-Deep Yellow

Carrots
Pumpkin
Sweet potato
Winter squash

Starchy

Breadfruit
Corn
Green peas
Hominy
Lima beans
Potato
Rutabaga
Taro

Dry Beans and Peas (Legumes)

Black beans
Black-eyed peas
Chickpeas (garbanzos)
Kidney beans
Lentils
Lima beans (mature)
Mung beans
Navy beans
Pinto beans
Split peas
Tofu

Other Vegetables

Artichoke
Asparagus
Bean and alfalfa sprouts
Beets
Brussels sprouts
Cabbage
Cauliflower
Celery
Chinese cabbage
Cucumber
Eggplant
Green beans
Green or red pepper
Lettuce
Mushrooms
Okra
Onions (mature and green)
Radishes
Snow peas
Summer squash
Tomato
Turnip
Vegetable juices
Wax beans
Zucchini

Hints:

- For variety, eat dark-green leafy vegetables, orange or deep-yellow vegetables, starchy vegetables, legumes, and other types of vegetables. Dark-green leafy vegetables, orange and deep-yellow vegetables, and legumes are particularly high in nutrients and fiber.
- Limit the fat you add to vegetables during cooking and at the table (as spreads and toppings).
- Legumes can be counted as servings of vegetables or as alternatives to meat.

Foods to try or emphasize:

_____ _____ _____
_____ _____ _____

GRAINS

Whole-Grain*

Amaranth
Brown rice
Buckwheat groats
Bulgar
Corn tortillas
Graham cracker
Granola
Millet
Oatmeal
Popcorn
Quinoa
Pumpernickel bread
Ready-to-eat cereals
Rye bread and crackers
Whole-wheat bread, rolls, crackers
Whole-wheat pasta
Whole-wheat cereals
Other: _____

Enriched

Bagels
Cornmeal
Crackers
English muffins
Farina
French bread
Grits
Hamburger and hot dog rolls
Italian bread
Macaroni
Noodles
Pancakes and waffles
Pretzels
Rice
Spaghetti
White bread and rolls
Other: _____

Grain Products with More Fat and Sugar

Biscuit
Cake (unfrosted)
Cookies
Cornbread
Croissant
Danish
Doughnut
Muffin
Pie crust
Tortilla chips

*Check labels on specific products to determine if they include whole grains.

(over)

Hints:

- Choose foods made from unprocessed, whole grains.
- Choose foods low in fat and sugars.
- Go easy on the fat and sugars you add as spreads, seasonings, or toppings.

Foods to try or emphasize:

_____ _____ _____
_____ _____ _____

MEAT AND BEANS

Meat, Poultry, and Fish				Alternatives	
Beef	Ham	Pork	Veal	Eggs	Peanut butter
Chicken	Lamb	Shellfish	Luncheon meats, sausage	Dry beans and peas (legumes)	Tofu
Fish	Organ meats	Turkey			_____
_____	_____	_____	_____	Nuts and seeds	_____
_____	_____	_____	_____	_____	_____

Hints:

- To limit your intake of fat and saturated fat, choose lean cuts of meat and skinless poultry. Trim away all the fat you can see. Watch serving sizes carefully.
- Choose at least one serving of plant proteins (legumes, tofu, nuts, seeds) per day.

Foods to try or emphasize:

_____ _____ _____
_____ _____ _____

MILK

Low-fat Milk Products		Other Milk Products with More Fat or Sugar			
Buttermilk	Low-fat or fat-free plain yogurt	Cheddar cheese	Frozen yogurt	Ice milk	Swiss cheese
Low-fat cottage cheese	Fat-free milk	Chocolate milk	Fruit yogurt	Process cheeses and spreads	Whole milk
Low-fat milk (1% and 2% fat)	_____	Flavored yogurt	Ice cream	_____	_____
_____	_____	_____	_____	Puddings made with milk	_____
		_____	_____	_____	_____

Hints:

• Choose low-fat or fat-free items to limit your overall fat intake. Limit serving sizes of high-fat choices.
• Cottage cheese is lower in calcium than most cheeses.

Foods to try or emphasize:

_____ _____ _____
_____ _____ _____

(over)

OILS, SOLID FATS, SWEETS, AND ALCOHOLIC BEVERAGES

Oils	Solid Fats		Sweets/Added Sugars		Alcoholic Beverages
Vegetable oil	Bacon, salt pork	Mayonnaise	Candy	Marmalade	Beer
Trans-free margarine	Butter	Salad dressing	Corn syrup	Popsicles and ices	Liquor
	Cream	Sour cream	Frosting (icing)	Sherbets	Wine
Low-fat mayonnaise	Cream cheese	Vegetable oil	Fruit drinks	Soft drinks and colas	_____
	Lard	_____	Honey		_____
Light salad dressing	Margarine	_____	Jam	Sugar (white and brown)	_____
	_____	_____	Jelly		_____
_____	_____	_____	Maple syrup	Table syrup	_____
_____	_____	_____	_____	_____	_____

Hints:

- Choose about 5–10 teaspoons of oils per day to obtain the essential fats.
- If your intake of solid fats, sweets and added sugars, and alcoholic beverages is high, consider developing a behavior change strategy to substitute healthier food choices from other groups.
- Limit your intake of reduced-fat versions of foods—they are often very high in both added sugar and calories.
- When choosing among different types of fats, favor unsaturated fats (vegetable and fish oils) over saturated and trans fats (animal fats, palm and coconut oils, hydrogenated fats).

INTERNET ACTIVITY

There are many variations on the basic USDA food guidance system—for people who follow a particular ethnic diet, for vegetarians, and for people in specific age groups. Visit one of the following sites and choose an alternative food plan or pyramid to investigate:

USDA: http://fnic.nal.usda.gov (click the "Dietary Guidance" link)
Harvard Nutrition Source: http://www.hsph.harvard.edu/nutritionsource/what-should-you-eat/pyramid/

Plan-pyramid chosen: _____

What are the food groups, and what are examples of foods from each one? How many servings are recommended for each?

Make up a day's diet that conforms to the plan-pyramid you've described:

SOURCE: U.S. Department of Agriculture. 2005. *MyPyramid: Inside the Pyramid* (http://mypyramid.gov/pyramid; retrieved December 1, 2008).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 64

How's Your Diet?

- For each question, circle the plus (+) or minus (–) score(s) that best reflects your diet. If you circle more than one score, average them by adding the scores and dividing by the number of scores you circled.
- For your final score, add your plus scores separately from your minus scores, then subtract your total minus scores from your total plus scores.
- Keep the quiz as incentive. Take it again in a few months to see if your habits have improved.

1. How many times a week do you eat red meat? (Include beef, lamb, pork, veal.)
   (a) 0 +4 (d) 5 or 6 –4
   (b) 1 or 2 +2 (e) More than 6 –5
   (c) 3 or 4 –2
2. How many ounces of red meat constitute your normal portion? (Hint: 3 ounces, cooked, is approximately the size of a deck of cards.)
   (a) 3 ounces +2 (c) 5 ounces –2
   (b) 4 ounces +1 (d) 6 or more ounces –3
3. What kind of red meat do you usually choose?
   (a) Loin or round cuts only +2
   (b) 80% lean +1
   (c) Ribs, T-bone –4
   (d) Hot dogs, bacon, bologna –5
4. How many times a week do you eat seafood? (Omit fried dishes; include shellfish like shrimp and lobster.)
   (a) 2 or more +4 (c) Less than 1 0
   (b) 1 +2 (d) Never –3
5. How many ounces of poultry or seafood do you eat for a serving? (Do not count fried items.)
   (a) 3 ounces +2 (c) 5 ounces –2
   (b) 4 ounces +1 (d) 6 or more ounces –3
6. Do you remove the skin from poultry?
   (a) Yes +2 (c) No –3
   (b) Don't eat poultry 0
7. How many times a week do you eat at least one half-cup serving of legumes? (Include beans like soybeans, navy, kidney, garbanzo, baked beans, lentils.)
   (a) 3 or more +4 (c) Less than 1 0
   (b) 1 or 2 +2 (d) Never eat legumes –1
8. What kind of milk do you drink?
   (a) Skim or 1% +3 (c) 2% –3
   (b) Don't drink milk 0 (d) Whole –4
9. What kind of cheese do you usually eat?
   (a) Fat-free +2
   (b) Low-fat (5 grams fat or less per ounce) +1
   (c) Don't eat cheese 0
   (d) Whole-milk cheese –4
10. How many servings of low-fat, high-calcium foods do you eat daily? (One cup of yogurt or milk, 2 ounces of cheese, or one cup chopped broccoli, kale, or greens count as a serving.)
    (a) 3 or more +4
    (b) 1 or 2 +2
    (c) 0 –3
11. What kind of bread do you eat most often?
    (a) 100% whole wheat +4
    (b) Whole grain +2
    (c) White, "wheat," Italian or French 0
    (d) Croissant or biscuit –4
12. Which is part of your most typical breakfast?
    (a) High-fiber cereal and fruit +4
    (b) Bagel or toast +1
    (c) Don't eat breakfast –2
    (d) Danish, pastry, or doughnut –3
13. What kind of sauce or topping is usually on the pasta you eat?
    (a) Vegetables tossed lightly with olive oil +3
    (b) Tomato or marinara sauce +2
    (c) Meat sauce –3
    (d) Alfredo or cream sauce –4
14. Which would you be most likely to order at a Chinese restaurant?
    (a) Chicken with steamed vegetables over white rice +3
    (b) Cold sesame noodles –1
    (c) Twice-fried pork –4
15. Which would you be most likely to choose as toppings for pizza?
    (a) Vegetables (e.g., broccoli, peppers) +3
    (b) Plain cheese 0
    (c) Extra cheese –3
    (d) Sausage and pepperoni –4

(over)

16. What is the most typical snack for you?
    (a) Fresh fruit +4
    (b) Low-fat yogurt +3
    (c) Pretzels +1
    (d) Potato chips –3
    (e) Candy bar –3
17. How many half-cup servings of a high vitamin C fruit or vegetable do you eat daily? (Include citrus fruit and juices, kiwi, papaya, strawberries, broccoli, peppers, potatoes, tomatoes.)
    (a) 2 or more +3
    (b) 1 +1
    (c) None –3
18. How many half-cup servings of a high vitamin A fruit or vegetable do you eat daily? (Include apricots, cantaloupe, mango, broccoli, carrots, greens, spinach, sweet potato, winter squash.)
    (a) 2 or more +3
    (b) 1 +1
    (c) None –3
19. What kind of salad dressing do you most often choose?
    (a) Fat-free or low-fat +3
    (b) Lemon juice or herb vinegar +3
    (c) Olive or canola oil-based +1
    (d) Creamy or cheese-based –3
20. What do you usually spread on bread, rolls, or bagels?
    (a) Nothing +1
    (b) Jam, jelly, or honey –1
    (c) Light butter or light margarine –2
    (d) Margarine –3
    (e) Butter –4
21. What spread do you usually choose for sandwiches?
    (a) Nothing +3
    (b) Mustard +2
    (c) Light mayonnaise –1
    (d) Mayonnaise, margarine, or butter –3
22. Which frozen dessert do you usually choose?
    (a) Don't eat frozen desserts +3
    (b) Fat-free frozen yogurt +1
    (c) Sorbet or sherbet +1
    (d) Light ice cream –2
    (e) Ice cream –4
23. How many cups of caffeinated beverages (e.g., coffee, tea, or soda) do you usually drink in a typical day?
    (a) None +2
    (b) 1 to 2 0
    (c) 3 or 4 –1
    (d) 5 or more –4
24. How many total cups of fluid do you drink in a typical day? (Include water, juice, milk.)
    (a) 8 or more +3
    (b) 6 to 7 +2
    (c) 4 or 5 +1
    (d) Less than 4 –1
25. What kind of cereal do you eat?
    (a) High-fiber cereals such as bran flakes +3
    (b) Low-fiber, low-sugar cereals, such as puffed rice, corn flakes, Corn Chex, or Cheerios 0
    (c) Sugary, low-fiber cereals, like Frosted Flakes, or fruit-flavored cereals –2
    (d) Regular (high-fat) granola –3
26. How many times a week do you eat fried foods?
    (a) never +4
    (b) 2 or less 0
    (c) 3 or more –3
27. How many times a week do you eat cancer-fighting cruciferous vegetables? (Include broccoli, cauliflower, brussels sprouts, cabbage, kale, bok choy, cooking greens, turnips, rutabaga.)
    (a) 3 or more +4
    (b) 1 to 2 +2
    (c) Rarely –4

Score: _____ – _____ = _____
(total of + answers) (total of – answers)

Scoring

65–82:	Excellent
42–64:	Very good
28–41:	Good
–16–27:	Fair
Below –16:	Get help!

SOURCE: Center for Science in the Public Interest. 1996. *Nutrition Action Health Letter.* Copyright © 1996 by Center for Science in the Public Interest. Reproduced with permission of Center for Science in the Public Interest in the format Textbook via Copyright Clearance Center.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 65

Determining Daily Energy and Macronutrient Intake Goals

Estimating Daily Energy Requirements

If your weight is stable, your current daily energy intake is the number of calories you need to consume to maintain your weight at your current activity level. You can determine the number of calories you consume on a particular day by keeping a careful and complete record of everything you eat and then totaling the number of calories in all the foods and beverages you consumed. This calculation can be done by hand, by using a nutrition analysis software program, or by using one of several Web sites that perform this type of analysis; for example, go to MyPyramid.gov and click on MyPyramid Tracker.

People often underestimate the size of their food portions, and so energy goals based on estimates of current calorie intake from food records can be inaccurate. You can also estimate your daily energy needs using the following formulas. To use the appropriate formula for your gender, you'll need to plug in the following:

- Age (in years)
- Weight (in pounds)
- Height (in inches)
- Physical activity coefficient (PA) from the table below; to help estimate your physical activity level, consider the following guidelines: Someone who walks briskly for 30 minutes per day (or the equivalent) in addition to the activities in a sedentary lifestyle is considered "low active"; someone who walks briskly for 90 minutes per day is considered "active."

Physical Activity Coefficient (PA)

Physical Activity Level	Men	Women
Sedentary	1.00	1.00
Low active	1.12	1.14
Active	1.27	1.27
Very active	1.54	1.45

Estimated Daily Energy Requirement for Weight Maintenance in Men

$864 - (9.72 \times \text{Age}) + (\text{PA} \times [(6.39 \times \text{Weight}) + (12.78 \times \text{Height})])$

1. 9.72 × _____ Age (years) = _____
2. 864 – _____ Result from step 1 = _____ [*result may be a negative number*]
3. 6.39 × _____ Weight (pounds) = _____
4. 12.78 × _____ Height (inches) = _____
5. _____ Result from step 3 + _____ Result from step 4 = _____
6. _____ PA (from table) × _____ Result from step 5 = _____
7. _____ Result from step 2 + _____ Result from step 6 = _____ Calories per day

Estimated Daily Energy Requirement for Weight Maintenance in Women

$387 - (7.31 \times \text{Age}) + (\text{PA} \times [(4.91 \times \text{Weight}) + (16.78 \times \text{Height})])$

1. 7.31 × _____ Age (years) = _____
2. 387 – _____ Result from step 1 = _____ [*result may be a negative number*]
3. 4.91 × _____ Weight (pounds) = _____
4. 16.78 × _____ Height (inches) = _____
5. _____ Result from step 3 + _____ Result from step 4 = _____
6. _____ PA (from table) × _____ Result from step 5 = _____
7. _____ Result from step 2 + _____ Result from step 6 = _____ Calories per day

(over)

Setting Intake Goals for Protein, Fat, and Carbohydrate

Once you have an estimate of your daily energy (calorie) needs, the next step is to set goals for daily intake from the three classes of macronutrients—protein, fat, and carbohydrate. You can allocate your total daily calories among the three classes of macronutrients to suit your preferences; just make sure that the three percentage values you select total 100% and that your values fall within the Acceptable Macronutrient Distribution Ranges (AMDRs) set by the Food and Nutrition Board of the National Academies. For example, you may choose targets of 15% of total daily calories from protein, 35% from fat, and 50% from carbohydrate. Fill in your percentage goals in the chart below:

Nutrient	AMDR (% of total daily calories)	Individual goals (% of total daily calories)
Protein	10–35%	_____ %
Fat	20–35%	_____ %
Carbohydrate	45–65%	_____ %
		100%

To translate your own percentage goals into daily intake goals expressed in calories and grams, multiply the percentages you've chosen by your total calorie intake and then divide the result by the corresponding calories per gram. (Use the total daily calorie goal you calculated in the first part of this worksheet and the percentage goals you set in the table above.) For example, a fat limit of 35% applied to a 2200-calorie diet would be calculated as follows: 0.35 × 2200 = 770 calories of total fat; 770 ÷ 9 calories per gram = 86 grams of total fat. (Remember, fat has 9 calories per gram and protein and carbohydrate have 4 calories per gram.)

Nutrient	Total calories	×	Macronutrient percentage goal (expressed as a decimal)	=	Calories per day of macronutrient	÷	Calories per gram of macronutrient	=	Grams per day of macronutrient
Protein	_____	×	_____	=	_____ calories/day	÷	4 calories/gram	=	_____ grams/day
Fat	_____	×	_____	=	_____ calories/day	÷	9 calories/gram	=	_____ grams/day
Carbohydrate	_____	×	_____	=	_____ calories/day	÷	4 calories/gram	=	_____ grams/day
Sample for fat	*2200*	×	*0.35*	=	*770 calories/day*	÷	*9 calories/gram*	=	*86 grams/day*

Summary of Goals

Total Daily Energy Intake: _____ calories per day

Macronutrients: Protein, Fat, Carbohydrate

Macronutrient	Percent of total daily calories	Calories per day	Grams per day
Protein	_____ %	_____ calories/day	_____ grams/day
Fat	_____ %	_____ calories/day	_____ grams/day
Carbohydrate	_____ %	_____ calories/day	_____ grams/day

To determine how close you are to meeting your personal intake goals, keep a running total over the course of the day. For prepared foods, food labels list the number of grams of fat, protein, and carbohydrate; the breakdown for popular fast-food items can be found in an appendix of your text. Nutrition information is also available in many grocery stores, in published nutrition guides, in nutrition analysis software, and online. By checking these resources, you can track the total grams of fat, protein, and carbohydrate you eat and assess your current diet.

SOURCE: Energy requirements and Acceptable Macronutrient Distribution Ranges taken from Food and Nutrition Board, Institute of Medicine, National Academies. 2002. *Dietary Reference Intakes: Energy, Carbohydrate, Fiber, Fat, Fatty Acids, Cholesterol, Protein, and Amino Acids.* Washington, D.C.: National Academy Press.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 66

Informed Food Choices

Part I. Using Food Labels

Choose three food items to evaluate. You might want to select three similar items, such as regular, low-fat, and fat-free salad dressing, or three very different items. Record the information from their food labels below.

Food Items			
Serving size			
Total calories	cal	cal	cal
Total fat—grams	g	g	g
—% Daily Value	%	%	%
Saturated fat—grams	g	g	g
—% Daily Value	%	%	%
Trans fat—grams	g	g	g
Cholesterol—milligrams	mg	mg	mg
—% Daily Value	%	%	%
Sodium—milligrams	mg	mg	mg
—% Daily Value	%	%	%
Carbohydrates (total)—grams	g	g	g
—% Daily Value	%	%	%
Dietary fiber—grams	g	g	g
—% Daily Value	%	%	%
Sugars—grams	g	g	g
Protein—grams	g	g	g
Vitamin A—% Daily Value	%	%	%
Vitamin C—% Daily Value	%	%	%
Calcium—% Daily Value	%	%	%
Iron—% Daily Value	%	%	%

How do the items you chose compare? You can do a quick nutrient check by totaling the Daily Value percentages for nutrients you should limit (total fat, cholesterol, sodium) and the nutrients you should favor (dietary fiber, vitamin A, vitamin C, calcium, iron) for each food. Which food has the largest percent Daily Value sum for nutrients to limit? For nutrients to favor?

Food Items			
Calories	cal	cal	cal
% Daily Value total nutrients to limit (total fat, cholesterol, sodium)	%	%	%
% Daily Value total nutrients to favor (fiber, vitamin A, vitamin C, calcium, iron)	%	%	%

(over)

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Insel/Roth, *Connect Core Concepts in Health,* Brief Twelfth Edition © 2012 The McGraw-Hill Companies, Inc. Chapter 9

Part II. Evaluating Fast Food

Complete the chart below for the last fast-food meal you ate. Add up your totals for the meal. Compare the values for fat, protein, carbohydrate, cholesterol, and sodium content for each food item and for the meal as a whole with the levels suggested by the Dietary Guidelines for Americans. Calculate the percentage of total calories derived from fat, saturated fat, protein, and carbohydrate using the formulas given.

You can obtain nutritional information by asking for a nutritional information brochure when you visit a restaurant or by visiting the restaurant's Web site: Arby's (http://www.arbysrestaurant.com), Burger King (http://www.burgerking.com), Jack in the Box (http://www.jackinthebox.com), KFC (http://www.kfc.com), McDonald's (http://www.mcdonalds.com), Subway (http://www.subway.com), Taco Bell (http://www.tacobell.com), Wendy's (http://www.wendys.com).

Food Items

	Dietary Guidelines							Total[b]
Serving size (g)		g	g	g	g	g	g	g
Calories		cal	cal	cal	cal	cal	cal	cal
Total fat—grams		g	g	g	g	g	g	g
—% calories[a]	20–35%	%	%	%	%	%	%	%
Saturated fat—grams		g	g	g	g	g	g	g
—% calories[a]	<10%	%	%	%	%	%	%	%
Protein—grams		g	g	g	g	g	g	g
—% calories[a]	10–35%	%	%	%	%	%	%	%
Carbohydrate—grams		g	g	g	g	g	g	g
—% calories[a]	45–65%	%	%	%	%	%	%	%
Cholesterol[c]	100 mg	mg	mg	mg	mg	mg	mg	mg
Sodium[c]	800 mg	mg	mg	mg	mg	mg	mg	mg

[a] To calculate the percentage of total calories from each food energy source (fat, carbohydrate, protein), use the following formula:

$$\frac{\text{(number of grams of energy source)} \times \text{(number of calories per gram of energy source)}}{\text{(total calories in serving of food item)}}$$

(*Note:* Fat and saturated fat provide 9 calories per gram; protein and carbohydrate provide 4 calories per gram). For example, the percentage of total calories from protein in a 150-calorie dish containing 10 grams of protein is

$$\frac{\text{(10 grams of protein)} \times \text{(4 calories per gram)}}{\text{(150 calories)}} = \frac{40}{150} = 0.27, \text{ or } 27\% \text{ of total calories from protein}$$

[b] For the Total column, add up the total grams of fat, carbohydrate, and protein contained in your sample meal and calculate the percentages based on the total calories in the meal. (Percentages may not total 100% due to rounding.) For cholesterol and sodium values, add up the total number of milligrams.

[c] Recommended daily limits of cholesterol and sodium are divided by 3 here to give an approximate recommended limit for a single meal.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 67

Reading Dietary Supplement Labels

Choose a dietary supplement label to evaluate; look for a product containing the "Supplement Facts" panel on its label. Use the information on the label to answer the following questions:

Name of product: _____ Price: $_____

Serving size:_____

Name and address of manufacturer: _____

_____

Contents:

Nutrients with established daily values and amount per serving:

Substances with no established daily values—list name, part of plant (for botanicals), and amount per serving:

Other ingredients:

Are standardization levels given for any of the substances contained in the supplement? If so, what are they?

Directions for use:

Are there any warnings or precautions for use of the product? If so, list them here. Do any apply to you?

Is there any other information relating to use or storage of the supplement?

(over)

Does the label contain any health-related claims? If so, list them in the appropriate category below.

Nutrient-content claims such as "high in . . . ," "excellent source of . . . ," or "high potency":

FDA-authorized claims about disease prevention (examples include the links between calcium and the prevention of osteoporosis, folate and the prevention of neural tube defects, and soluble fiber and the prevention of heart disease); claims may be authorized or qualified:

Structure-function claims such as "antioxidants maintain cell integrity"; these claims carry a disclaimer stating that they have not been evaluated by the FDA and that the product is not intended to diagnose, treat, cure, or prevent disease:

Does the label or packaging include any other elements—artwork, photographs, and so on—that imply that use of the supplement will have a particular effect?

Does the supplement contain the USP-DSVP designation from the U.S. Pharmacopoeia? The NNFA designation from the National Nutritional Foods Association? Any other indication of quality or purity?

Has a close study of the label changed your opinion about the product and made you more or less likely to try it? Why or why not?

(over)

INTERNET ACTIVITY

The responsibility for becoming informed about dietary supplements is currently left primarily to the consumer. Investigate one ingredient in the dietary supplement you used to complete this worksheet. Use the resources listed below or do a search to locate at least one research study on the substance you've chosen to investigate. If you locate a large number of studies, choose one that relates to the claims made on the supplement label you reviewed. Once you find an appropriate study, write a brief description of it.

National Library of Medicine: PubMed: http://www.ncbi.nlm.nih.gov/PubMed
NIH Office of Dietary Supplements: http://dietary-supplements.info.nih.gov
National Center for Complementary and Alternative Medicine: http://nccam.nih.gov

Site visited (URL): _____

Substance: _____

Citation of study: _____

_____

Brief description of study:

Finally, search the FDA's Web site (http://www.fda.gov) for the substance you investigated. You may find a health warning, a report of an adverse effect associated with its use, or other helpful materials. Briefly describe any information you find there:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 68

Food Safety Quiz

Fill in the correct answer to each question:

____ 1. The temperature of the refrigerator in my home is
   a. 50 degrees Fahrenheit (10 degrees Celsius).
   b. 40°F (5°C).
   c. I don't know; I've never measured it.

____ 2. The last time we had leftover cooked stew or other food with meat, chicken, or fish, the food was
   a. cooled to room temperature, then put in the refrigerator.
   b. put in the refrigerator immediately after the food was served.
   c. left at room temperature overnight or longer.

____ 3. The last time the kitchen sink drain, disposal, and connecting pipe in my home were sanitized was
   a. last night.
   b. several weeks ago.
   c. can't remember.

____ 4. If a cutting board is used in my home to cut raw meat, poultry, or fish and it is going to be used to chop another food, the board is
   a. reused as is.
   b. wiped with a damp cloth.
   c. washed with soap and hot water.
   d. washed with soap and hot water and then sanitized.

____ 5. The last time we had hamburgers in my home, I ate mine
   a. rare (140°F).
   b. medium (160°F).
   c. well-done (170°F).

____ 6. The last time there was cookie dough in my home, the dough was
   a. made with raw eggs, and I sampled some of it.
   b. made with raw eggs and refrigerated, then I sampled some of it.
   c. store-bought, and I sampled some of it.
   d. not sampled until baked.

____ 7. I clean my kitchen counters and other surfaces that come in contact with food with
   a. water.
   b. hot water and soap.
   c. hot water and soap, then bleach solution.
   d. hot water and soap, then commercial sanitizing agent.

____ 8. When dishes are washed in my home, they are
   a. washed and dried in an automatic dishwasher.
   b. left to soak in the sink for several hours and then washed with soap in the same water.
   c. washed right away with hot water and soap in the sink and then air-dried.
   d. washed right away with hot water and soap in the sink and immediately towel-dried.

(over)

____ 9. The last time I handled raw meat, poultry, or fish, I cleaned my hands afterwards by
a. wiping them on a towel.
b. rinsing them under hot, cold, or warm tap water.
c. washing with soap and warm water.

____ 10. Meat, poultry, and fish products are defrosted in my home by
a. setting them on the counter.
b. placing them in the refrigerator.
c. microwaving.

____ 11. When I buy fresh seafood, I
a. buy only fish that's refrigerated or well iced.
b. take it home immediately and put it in the refrigerator.
c. sometimes buy it straight out of a local fisher's creel.

____ 12. I realize people, including myself, should be especially careful about not eating raw seafood if they have
a. diabetes.
b. HIV infection.
c. cancer.
d. liver disease.

Answers

1. B (2 points)
2. B (2 points)
3. A (2 points) or B (1 point)
4. D (2 points)
5. B or C (2 points)
6. D (2 points)
7. C or D (2 points); B (1 point)
8. A or C (2 points)
9. C (2 points)
10. B or C (2 points)
11. A and B (2 points)
12. All answers are correct (2 points)

Scoring

24 points:	Feel confident about the safe food practices you follow in your home.
12 to 23 points:	Reexamine food safety practices in your home. Some key rules are being violated.
11 points or below:	Take steps immediately to correct food handling, storage and cooking techniques used in your home. Current practices are putting you and other members of your household in danger of foodborne illness.

SOURCE: Food and Drug Administration. 2002. *Can your kitchen pass the food safety test?* FDA Publication No. (FDA) 02-1229.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 69

Your Physical Activity Profile

For health benefits and successful weight management, 30–60 or more minutes of daily physical activity is recommended. How close are you to meeting this recommendation? To develop a physical activity profile, begin by monitoring your activities on a typical day. Complete the chart below by filling in your activities and the amount of time you spend on each one; in addition, keep track of the number of flights of stairs you climb. Be sure the activities in your log total 24 hours. Classify each activity as sleep or as light, moderate, or vigorous according to the following guidelines:

Light activities: Walking slowly; routine tasks such as cooking or shopping; light housework such as ironing, dusting, or washing dishes; light yard work or home activities such as pruning, weeding, or plumbing; or light fitness activities such as light stretching, warming up, swimming slowly or slowly treading water.

Moderate activities: Walking briskly; cycling moderately on level terrain; social dancing; moderate housework such as scrubbing floors or washing windows; moderate yard work or home activities such as planting, raking, painting, or washing a car; fitness activities requiring moderate effort such as low-impact aerobics, playing Frisbee, swimming, or playing doubles' tennis.

Vigorous activities: Walking briskly uphill; cycling on steep uphill terrain; heavy housework such as moving furniture or carrying heavy objects upstairs; vigorous yard work or home activities such as shoveling snow, trimming trees, doing construction work, or digging; fitness activities requiring vigorous effort such as running, high-impact aerobics, circuit weight training, swimming laps, and most competitive sports.

Activity	Duration	Classification

Number of flights of stairs: _____ flights

(over)

Physical Activity Summary (should total 24 hours)

Sleep	hours
Light activity	hours
Moderate activity	hours
Vigorous activity	hours
Flights of stairs	flights

If you want to increase the amount of moderate or vigorous physical activity in your life, begin by analyzing the amount of time you spend in each intensity category according to the type of activity:

	Light activity	Moderate activity	Vigorous activity
Home and child-care activities	hours	hours	hours
School- or job-related activities	hours	hours	hours
Transportation-related activities	hours	hours	hours
Leisure activities	hours	hours	hours
Exercise/sport activities	hours	hours	hours

Increasing Daily Physical Activity

How much of your time in transportation-related activities and leisure activities is classified as light activity? Transportation and leisure activities are often the areas where it is easiest to substitute moderate activities for light activities. Examples include walking or biking rather than driving for short errands and going for a walk with a friend rather than chatting on the phone; refer to your text for additional suggestions. Below, identify three strategies for boosting physical activity in your daily life:

1. _____

2. _____

3. _____

Can you also identify additional opportunities to climb stairs each day? If so, list them here:

Your next step is to begin to adopt the strategies you've identified to increase physical activity. To monitor your progress, keep a daily journal of your physical activity based on the style of the charts shown in this worksheet.

SOURCE: Activity classifications from CDC Division of Nutrition and Physical Activity. 1999. *Promoting Physical Activity: A Guide for Community Action.* Champaign, Ill.: Human Kinetics.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 70

Safety of Exercise Participation

People of any age who are not at high risk for serious health problems can safely exercise at a moderate intensity (60% or less of maximum heart rate) without a prior medical evaluation. Likewise, if you are male and under 40 or female and under 50 and in good health, exercise is probably safe for you. If you are over these ages or have health problems, especially high blood pressure, heart disease, muscle or joint problems, or obesity, see your physician before starting a vigorous exercise program. The Canadian Society for Exercise Physiology has developed the Physical Activity Readiness Questionnaire (PAR-Q) to help determine exercise safety; this questionnaire appears on the next page.

To further assess the safety of exercise for you, complete as much of the following health profile as possible. If the PAR-Q or anything on the general health profile indicate that you should see your physician before beginning an exercise program, or if you have any questions about the safety of exercise for you, make an appointment to talk with your health care provider to address your concerns.

General Health Profile for Exercise Safety

General Information

Age: _____ Total cholesterol: _____ Blood pressure: ____ / ____

Height: _____ HDL: _____ Triglycerides: _____

Weight: _____ LDL: _____ Blood glucose: _____

Are you currently trying to ____ gain or ____ lose weight? (check one if appropriate)

Medical Conditions/Treatments

Check any of the following that apply to you, and add any other conditions that might affect your ability to exercise safely:

____ heart disease
____ lung disease
____ diabetes
____ allergies
____ asthma
____ eating disorder
____ substance abuse problem
____ back pain
____ arthritis
____ other injury or joint problem: _____
____ depression, anxiety, or another psychological disorder
____ other: _____
____ other: _____
____ family history of cardiovascular disease (a parent, sibling, or child who had a heart attack or stroke before age 55 for men or 65 for women)

List any prescription and over-the-counter medications or supplements you are taking or any medical treatments you are undergoing. Include the name of the substance or treatment and its purpose:

_____ _____

_____ _____

Lifestyle Information

Check any of the following that is true for you, and fill in the requested information.

____ I usually eat high-fat foods (fatty meats, cheese, fried foods, butter, full-fat dairy products) every day.
____ I consume fewer than 7 servings of fruits and vegetables on most days.
____ I smoke cigarettes or use other tobacco products, or I am regularly exposed to ETS. If true, describe use/exposure: _____
____ I regularly drink alcohol. If true, describe consumption pattern: _____
_____
____ I often feel that I need more sleep. (I need about ____ hours per day; I get about ____ hours per day.)
____ I feel that stress has adversely affected my level of wellness during the past year.

Describe your current activity pattern. What types of moderate and vigorous activity do you engage in on a daily or weekly basis? _____

_____ *(over)*

Physical Activity Readiness Questionnaire - PAR-Q (revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered

YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT or GUARDIAN (for participants under the age of majority) _____ WITNESS _____

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

© Canadian Society for Exercise Physiology

Supported by: Health Canada Santé Canada

SOURCE: Physical Activity Readiness Questionnaire (PAR-Q) © 2002. Used with permission from the Canadian Society for Exercise Physiology. www.csep.ca

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 71

Using a Pedometer to Track Physical Activity

How physically active are you? Would you be more motivated to try to increase daily physical activity if you had an easy way to monitor your level of activity? If so, consider wearing a pedometer to track the number of steps you take each day—a rough but easily obtainable reflection of daily physical activity.

Determine Your Baseline

Wear the pedometer for a week to obtain a baseline average daily number of steps.

	M	T	W	Th	F	Sa	Su	Average
Steps								

Set Goals

Set an appropriate goal for increasing steps. The goal of 10,000 steps per day is widely recommended, but your personal goal should reflect your baseline level of steps. For example, if your current daily steps are far below 10,000, a goal of walking 2,000 additional steps each day might be appropriate. If you are already close to 10,000 steps per day, choose a higher goal. Also consider the physical activity goals in the 2005 Dietary Guidelines:

- To reduce the risk of chronic disease, aim to accumulate at least 30 minutes of moderate physical activity per day.
- To help manage body weight and prevent gradual, unhealthy weight gain, engage in 60 minutes of moderately to vigorously intense activity on most days of the week.
- To sustain weight loss, engage in at least 60–90 minutes of daily moderate-intensity physical activity.

To help gauge how close you are to meeting these time-based physical activity goals, you might walk for 10 or 15 minutes while wearing your pedometer to determine how many steps correspond with the time-based goals from the Dietary Guidelines.

Once you have set your overall goal, break it down into several steps. Smaller goals are easier to achieve and can help keep you motivated and on track. Having several interim goals also gives you the opportunity to reward yourself more frequently. Note your goals below:

Minigoal 1: _____ Target date: _____ Reward: _____
Minigoal 2: _____ Target date: _____ Reward: _____
Minigoal 3: _____ Target date: _____ Reward: _____
Overall goal: _____ Target date: _____ Reward: _____

Develop Strategies for Increasing Steps

What can you do to become more active? Your text includes a variety of suggestions, including walking when you do errands, getting off one stop down the line from your destination on public transportation, parking an extra block or two away from your destination, and doing at least one chore every day that requires physical activity. If weather or neighborhood safety is an issue, look for alternative locations to walk. For example, find an indoor gym or shopping mall or even a long hallway. Check out locations that are near or on the way between your campus, workplace, or residence. If you think walking indoors will be dull, walk with friends or family members or wear headphones (if safe) and listen to music or audio books.

Are there any days of the week for which your baseline steps are particularly low and/or it will be especially difficult because of your schedule to increase your number of steps? Be sure to develop specific strategies for difficult situations.

(over)

Below, list at least five strategies for increasing daily steps:

Track Your Progress

Based on the goals you set, fill in your goal portion of the progress chart with your target average daily steps for each week. Then, wear your pedometer every day and note your total daily steps. Track your progress toward each minigoal and your final goal. Every few weeks, stop and evaluate your progress. If needed, adjust your plan and develop additional strategies for increasing steps. In addition to the chart in this worksheet, you might also want to graph your daily steps to provide a visual reminder of how you are progressing toward your goals. Make as many copies of this chart as you need.

Week	Goal	M	Tu	W	Th	F	Sa	Su	Average
1									
2									
3									
4									

Progress Check up

How close are you to meeting your goal? How do you feel about your program and your progress?

If needed, describe changes to your plan and additional strategies for increasing steps:

Week	Goal	M	Tu	W	Th	F	Sa	Su	Average
5									
6									
7									
8									

Progress Check up

How close are you to meeting your goal? How do you feel about your program and your progress?

If needed, describe changes to your plan and additional strategies for increasing steps:

Week	Goal	M	Tu	W	Th	F	Sa	Su	Average
9									
10									
11									
12									

Progress Check up

How close are you to meeting your goal? How do you feel about your program and your progress?

If needed, describe changes to your plan and additional strategies for increasing steps:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 72

Evaluating Your Fitness Level

Once you've decided whether you should obtain medical clearance before making a change in your exercise program, the next step is to assess your current level of physical fitness. The tests presented here will enable you to make a relatively simple assessment of cardiorespiratory endurance (CRE), muscular endurance, and flexibility. The results from these tests can help show you what to focus on as you develop a fitness program.

Part I. Cardiorespiratory Endurance

1.5-Mile Run-Walk Test

Don't attempt this test unless you have completed at least 6 weeks of some type of conditioning activity and, if indicated by Wellness Worksheet 70, have obtained medical clearance. You may want to practice pacing yourself prior to taking the test to avoid going too fast at the start and becoming fatigued before you finish. Allow yourself a day or two to recover from your practice run before taking the test. Before beginning this test, warm up with some walking, easy jogging, and stretching exercises.

1. Ask someone with a stopwatch, clock, or watch with a second hand to time you.
2. Take the test on a running track or course that is flat and provides measurements of up to 1.5 miles. Cover the distance as fast as possible, at a pace that is comfortable for you. You can run or walk the entire distance or use some combination of running and walking.
3. Note the time it takes you to complete the 1.5-mile distance.

   Your time: ____ : ____ (minutes:seconds)
4. Cool down by walking or jogging slowly for about 5 minutes.
5. Determine the rating for your score by consulting the table below. If you are unable to complete the entire 1.5 miles, consider yourself very poor in CRE.

Standards for the 1.5-Mile Run-Walk Test (minutes:seconds)

Women	*Superior*	*Excellent*	*Good*	*Fair*	*Poor*	*Very Poor*
Age: 20–29	9:23–10:20	10:59–11:56	12:07–13:25	13:58–15:05	15:32–17:11	17:53–25:17
30–39	9:52–11:08	11:43–12:53	13:08–14:33	14:33–15:56	16:43–18:18	19:01–25:10
40–49	10:09–11:35	12:25–13:38	13:58–15:17	15:56–17:11	17:38–19:43	20:49–27:55
50–59	11:34–13:16	13:58–15:14	15:47–17:19	17:38–19:10	19:43–21:57	22:53–30:34
60–69	12:25–14:28	15:32–16:46	17:34–18:52	19:29–20:55	22:03–23:55	25:02–33:05
70–79	12:25–14:33	16:06–18:05	18:39–20:54	21:45–23:47	24:54–27:17	27:55–37:26

Men	*Superior*	*Excellent*	*Good*	*Fair*	*Poor*	*Very Poor*
Age: 20–29	8:22–9:10	9:34–10:08	10:34–11:27	11:34–12:29	12:53–13:58	14:33–20:55
30–39	8:49–9:31	9:52–10:38	10:59–11:49	11:58–12:53	13:25–14:33	15:14–20:55
40–49	9:02–9:47	10:09–11:09	11:32–12:25	12:53–13:50	14:10–15:32	16:09–22:22
50–59	9:31–10:27	11:09–12:08	12:37–13:53	13:58–15:14	15:53–17:30	18:22–27:08
60–69	10:09–11:20	12:10–13:25	13:58–15:20	15:53–17:19	17:49–20:13	21:34–31:59
70–79	10:27–12:25	13:25–14:52	15:38–17:37	18:05–19:43	20:28–23:55	25:49–33:30

SOURCES: Formula for maximal oxygen consumption taken from McArdle, W. D., F. I. Katch, and V. L. Katch. 1991. *Exercise Physiology: Energy, Nutrition, and Human Performance.* Philadelphia: Lea & Febiger, pp. 225–226. Standards from Cooper Institute. 2007. *PTr (Personal Trainer) Course Manual*. Cooper Institute: Dallas, Texas. © 2010 The Cooper Institute. Reprinted with permission from The Cooper Institute, Dallas, Texas, from a book called *Physical Fitness Assessments and Norms for Adults and Law Enforcement*. Available online at www.cooperinstitute.org. Used with permission.

(over)

12-Minute Wheelchair Performance Test

1. Warm up before taking the test. Take the test on a track or course that is flat and provides exact distance measurements in miles.
2. Travel at a steady pace, as fast as possible without undue fatigue, for the entire 12 minutes. Cool down after the test is over.
3. Record the distance you traveled in miles, using a decimal figure. Distance traveled: _____ miles

Ratings for the 12-Minute Wheelchair Performance Test

Distance (miles)	*Fitness Level*
Below 0.63	Poor
0.63–0.86	Below average
0.87–1.35	Fair
1.36–1.59	Good
Above 1.59	Excellent

SOURCE: Reprinted from Franklin, B. A., et al. 1990. Field test estimation of maximal oxygen consumption in wheelchair users. *Archives of Physical Medicine and Rehabilitation* 71:574–578. Copyright © 1990 with permission from The American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine Rehabilitation.

Part II. Muscular Strength and Endurance

The Curl-Up Test

Place 12-inch strips of tape or Velcro 3 inches apart on a mat or other testing surface. Try a few curl-ups to get used to the proper technique and warm up your muscles.

1. Start by lying on your back on the floor or mat, arms straight and by your sides, shoulders relaxed, palms down and on the floor, and fingers straight. Adjust your position so that the longest fingertip of each hand touches the end of the near strip of Velcro or tape. Your knees should be bent about 90 degrees, with your feet about 12–18 inches from your buttocks.
2. To perform a curl-up, flex your spine while sliding your fingers across the floor until the fingertips of each hand reach the second strip of Velcro or tape. Then, return to the starting position; the shoulders must be returned to touch the mat between curl-ups, but the head need not touch. Shoulders must remain relaxed throughout the curl-up, and feet and buttocks must stay on the floor. Breathe easily, exhaling during the lift phase of the curl-up; *do not hold your breath.*
3. When someone signals you to begin, perform as many curl-ups as you can at a steady pace with correct form. Continue until you drop your pace or are unable to maintain correct form.
   Number of curl-ups performed with correct form: _____

Ratings for the Curl-Up Test

		Number of Curl-Ups					
Men		*Very Poor*	*Poor*	*Average*	*Good*	*Excellent*	*Superior*
Age:	16–19	Below 48	48–57	58–64	65–74	75–93	Above 93
	20–29	Below 46	46–54	55–63	64–74	75–93	Above 93
	30–39	Below 40	40–47	48–55	56–64	65–81	Above 81
	40–49	Below 38	38–45	46–53	54–62	63–79	Above 79
	50–59	Below 36	36–43	44–51	52–60	61–77	Above 77
	60–69	Below 33	33–40	41–48	49–57	58–74	Above 74

(over)

Number of Curl-Ups

Women	*Very Poor*	*Poor*	*Average*	*Good*	*Excellent*	*Superior*
Age: 16–19	Below 42	42–50	51–58	59–67	68–84	Above 84
20–29	Below 41	41–51	52–57	58–66	67–83	Above 83
30–39	Below 38	38–47	48–56	57–66	67–85	Above 85
40–49	Below 36	36–45	46–54	55–64	65–83	Above 83
50–59	Below 34	34–43	44–52	53–62	63–81	Above 81
60–69	Below 31	31–40	41–49	50–59	60–78	Above 78

SOURCE: Ratings based on norms calculated from data collected by Robert Lualhati on 4545 college students, 16–80 years of age, at Skyline College, San Bruno, California. Used with permission.

The Push-Up Test

In this test, you will perform either standard push-ups or modified push-ups, in which you support yourself with your knees. The Cooper Institute developed the ratings for this test with men performing push-ups and women performing modified push-ups.

1. *For push-ups:* Start in the push-up position with your body supported by your hands and feet. *For modified push-ups:* Start in the modified push-up position with your body supported by your hands and knees. *For both positions:* Your arms and your back should be straight and your fingers pointed forward.
2. Lower your chest to the floor with your back straight, then return to the starting position.
3. Perform as many push-ups or modified push-ups as you can without stopping.
   Number of push-ups: _____ or number of modified push-ups: _____

Ranges for the Push-Up and Modified Push-Up Tests

Number of Push-Ups

Men	*Superior*	*Excellent*	*Good*	*Fair*	*Poor*	*Very Poor*
Age: 20–29	62–100	47–57	37–44	29–35	22–27	13–19
30–39	52–86	39–46	30–36	24–29	17–21	9–15
40–49	40–64	30–36	24–29	18–22	11–16	5–10
50–59	39–51	25–30	19–24	13–17	9–11	3–7
60+	28–39	23–26	18–22	10–16	6–9	2–5

Number of Modified Push-Ups

Women	*Superior*	*Excellent*	*Good*	*Fair*	*Poor*	*Very Poor*
Age: 20–29	45–70	36–42	30–34	23–29	17–22	9–15
30–39	39–56	31–36	24–29	19–23	11–17	4–9
40–49	33–60	24–28	18–21	13–17	6–11	1–4
50–59	28–31	21–25	17–20	12–15	6–10	0–4
60+	20–20	15–17	12–15	5–12	2–4	0–1

SOURCE: Based on norms from the Cooper Institute for Aerobics Research, Dallas, Texas. *The Physical Fitness Specialist* Manual. © 2010 The Cooper Institute. Reprinted with permission from The Cooper Institute, Dallas, Texas, from a book called *Physical Fitness Assessments and Norms for Adults and Law Enforcement*. Available online at www.cooperinstitute.org. Used with permission.

(over)

Part III. Flexibility

Sit-and-Reach Test

For this test, use a modified Wells and Dillon flexometer or construct your own measuring device using a firm box or two pieces of wood 12 inches high attached at right angles to each other. Place the box or wood device against a wall and attach a metric ruler to measure the extent of reach. With the low numbers of the ruler toward the person being tested, set the 26-centimeter mark of the ruler at the footline of the box. (Individuals who cannot reach as far as the footline will have scores below 26 centimeters; those who can reach past their feet will have scores above 26 centimeters.)

1. Warm up your muscles with a low-intensity activity such as walking, and then perform slow stretching movements.
2. Remove your shoes and sit facing the flexibility measuring device with your knees fully extended and your feet flat against the device about 4 centimeters apart.
3. Reach as far forward as you can, with palms down, arms evenly stretched, and knees fully extended; hold the position of maximum reach for about 2 seconds.
4. Perform the stretch two times, recording the maximum reading to the nearest 0.5 centimeters: _____ cm.

Ratings for Sit-and-Reach Test

		*Rating/Score (cm.)**				
Men		*Needs Improvement*	*Fair*	*Good*	*Very Good*	*Excellent*
Age:	15–19	Below 24	24–28	29–33	34–38	Above 38
	20–29	Below 25	25–29	30–33	34–39	Above 39
	30–39	Below 23	23–27	28–32	33–37	Above 37
	40–49	Below 18	18–23	24–28	29–34	Above 34
	50–59	Below 16	16–23	24–27	28–34	Above 34
	60–69	Below 15	15–19	20–24	25–32	Above 32
Women						
Age:	15–19	Below 29	29–33	34–37	38–42	Above 42
	20–29	Below 28	28–32	33–36	37–40	Above 40
	30–39	Below 27	27–31	32–35	36–40	Above 40
	40–49	Below 25	25–29	30–33	34–37	Above 37
	50–59	Below 25	25–29	30–32	33–38	Above 38
	60–69	Below 23	23–36	27–30	31–34	Above 34

*Footline is set at 26 cm.

SOURCE: Ratings from *Canadian Physical Activity, Fitness & Lifestyle Approach: CSEP Health & Fitness Program's Health-Related Appraisal and Counselling Strategy,* Third Edition. © 2003. Reprinted with permission of the Canadian Society for Exercise Physiology.

A Summary of Your Fitness

Components and Tests	*Rating*
Cardiorespiratory endurance 1.5-mile run-walk test or 12-minute wheelchair performance test	
Muscular strength and endurance 60-second sit-up test Push-up or modified push-up test	
Flexibility Sit-and-reach test	

Use the information in this summary chart to help choose activities for your fitness program.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 73

Overcoming Barriers to Being Active

Barriers to Being Active Quiz

Directions: Listed below are reasons that people give to describe why they do not get as much physical activity as they think they should. Please read each statement and indicate how likely you are to say each of the following statements:

How likely are you to say?	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely
1. My day is so busy now, I just don't think I can make the time to include physical activity in my regular schedule.	3	2	1	0
2. None of my family members or friends like to do anything active, so I don't have a chance to exercise.	3	2	1	0
3. I'm just too tired after work to get any exercise.	3	2	1	0
4. I've been thinking about getting more exercise, but I just can't seem to get started.	3	2	1	0
5. I'm getting older, so exercise can be risky.	3	2	1	0
6. I don't get enough exercise because I have never learned the skills for any sport.	3	2	1	0
7. I don't have access to jogging trails, swimming pools, bike paths, etc.	3	2	1	0
8. Physical activity takes too much time away from other commitments—like work, family, etc.	3	2	1	0
9. I'm embarrassed about how I will look when I exercise with others.	3	2	1	0
10. I don't get enough sleep as it is. I just couldn't get up early or stay up late to get some exercise.	3	2	1	0
11. It's easier for me to find excuses not to exercise than to go out and do something.	3	2	1	0
12. I know of too many people who have hurt themselves by overdoing it with exercise.	3	2	1	0
13. I really can't see learning a new sport at my age.	3	2	1	0
14. It's just too expensive. You have to take a class or join a club or buy the right equipment.	3	2	1	0
15. My free times during the day are too short to include exercise.	3	2	1	0
16. My usual social activities with family or friends do not include physical activity.	3	2	1	0

(over)

How likely are you to say?	Very likely	Somewhat likely	Somewhat unlikely	Very unlikely
17. I'm too tired during the week, and I need the weekend to catch up on my rest.	3	2	1	0
18. I want to get more exercise, but I just can't seem to make myself stick to anything.	3	2	1	0
19. I'm afraid I might injure myself or have a heart attack.	3	2	1	0
20. I'm not good enough at any physical activity to make it fun.	3	2	1	0
21. If we had exercise facilities and showers at work, then I would be more likely to exercise.	3	2	1	0

Scoring

- Enter the circled number in the spaces provided, putting the number for statement 1 on line 1, statement 2 on line 2, and so on.
- Add the three scores on each line. Your barriers to physical activity fall into one or more of seven categories: lack of time, social influence, lack of energy, lack of willpower, fear of injury, lack of skill, and lack of resources. A score of 5 or above in any category shows that this is an important barrier for you to overcome. For your key barriers, try the strategies listed on the following pages and/or develop additional strategies that work for you. Check off any strategy that you try.

____	+	____	+	____	=	_____
1		8		15		Lack of time
____	+	____	+	____	=	_____
2		9		16		Social influence
____	+	____	+	____	=	_____
3		10		17		Lack of energy
____	+	____	+	____	=	_____
4		11		18		Lack of willpower
____	+	____	+	____	=	_____
5		12		19		Fear of injury
____	+	____	+	____	=	_____
6		13		20		Lack of skill
____	+	____	+	____	=	_____
7		14		21		Lack of resources

(over)

Suggestions for Overcoming Physical Activity Barriers

Lack of time

____ Identify available time slots. Monitor your daily activities for 1 week. Identify at least three 30-minute time slots you could use for physical activity.

____ Add physical activity to your daily routine. For example, walk or ride your bike to work or shopping, organize social activities around physical activity, walk the dog, exercise while you watch TV, park farther from your destination, and so on.

____ Make time for physical activity. For example, walk, jog, or swim during your lunch hour, or take fitness breaks instead of coffee breaks.

____ Select activities requiring minimal time, such as walking, jogging, stair climbing.

____ Other: _____

Social influence

____ Explain your interest in physical activity to friends and family. Ask them to support your efforts.

____ Invite friends and family members to exercise with you. Plan social activities involving exercise.

____ Develop new friendships with physically active people. Join a group, such as the YMCA or a hiking club.

____ Other: _____

Lack of energy

____ Schedule physical activity for times in the day or week when you feel energetic.

____ Convince yourself that if you give it a chance, exercise will increase your energy level; then, try it.

____ Other: _____

Lack of willpower

____ Plan ahead. Make physical activity a regular part of your daily or weekly schedule and write it on your calendar.

____ Invite a friend to exercise with you on a regular basis and write it on both your calendars.

____ Join an exercise group or class.

____ Other: _____

Fear of injury

____ Learn how to warm up and cool down to prevent injury.

____ Learn how to exercise appropriately considering your age, fitness level, skill level, and health status.

____ Choose activities involving minimal risk.

____ Other: _____

Lack of skill

____ Select activities requiring no new skills, such as walking, climbing stairs, or jogging.

____ Exercise with friends who are at the same skill level as you are.

____ Find a friend who is willing to teach you some new skills.

____ Take a class to develop new skills.

____ Other: _____

Lack of resources

____ Select activities that require minimal facilities or equipment, such as walking, jogging, jumping rope, or calisthenics.

(over)

____ Identify inexpensive, convenient resources available in your community (community education programs, park and recreation programs, worksite programs, etc.).

____ Other: _____

Are any of the following additional barriers important for you? If so, try some of the strategies listed here or invent your own.

Weather conditions

____ Develop a set of regular activities that are always available regardless of weather (indoor cycling, aerobic dance, indoor swimming, calisthenics, stair climbing, rope skipping, mall walking, dancing, gymnasium games, etc.).

____ Look on outdoor activities that depend on weather conditions (cross-country skiing, outdoor swimming, outdoor tennis, etc.) as "bonuses"—extra activities possible when weather and circumstances permit.

____ Other: _____

Travel

____ Put a jump rope in your suitcase and jump rope.

____ Walk the halls and climb the stairs in hotels.

____ Stay in places with swimming pools or exercise facilities.

____ Join the YMCA or YWCA (ask about reciprocal membership agreement).

____ Visit the local shopping mall and walk for half an hour or more.

____ Bring a small tape recorder and your favorite aerobic exercise tape.

____ Other: _____

Family obligations

____ Trade babysitting time with a friend, neighbor, or family member who also has small children.

____ Exercise with the kids—go for a walk together, play tag or other running games, get an aerobic dance or exercise tape for kids (there are several on the market) and exercise together. You can spend time together and still get your exercise.

____ Hire a babysitter and look at the cost as a worthwhile investment in your physical and mental health.

____ Jump rope, do calisthenics, ride a stationary bicycle, or use other home gymnasium equipment while the kids watch TV or when they are sleeping.

____ Try to exercise when the kids are not around (e.g., during school hours or their nap time).

____ Other: _____

Retirement years

____ Look on your retirement as an opportunity to become more active instead of less. Spend more time gardening, walking the dog, and playing with your grandchildren. Children with short legs and grandparents with slower gaits are often great walking partners.

____ Learn a new skill you've always been interested in, such as ballroom dancing, square dancing, or swimming.

____ Now that you have the time, make regular physical activity a part of every day. Go for a walk every morning or every evening before dinner. Treat yourself to an exercycle and ride every day during a favorite TV show.

____ Other: _____

SOURCE: CDC Division of Nutrition and Physical Activity. 1999. *Promoting Physical Activity: A Guide for Community Action.* Champaign, Ill.: Human Kinetics.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 74

Personal Fitness Program Plan and Contract

A. I, _____, am contracting with myself to follow a physical fitness
(name)

program to work toward the following goals:

1. _____
2. _____
3. _____
4. _____
5. _____

B. My program plan is as follows:

Activities	Components (Check ✔)					Frequency (Check ✔)							Intensity	Time
	CRE	MS	ME	F	BC	M	Tu	W	Th	F	Sa	Su		

C. My program will begin on _____. My program includes the following schedule of
(date)

minigoals. For each step in my program, I will give myself the reward listed.

_____ _____ _____
(minigoal 1) (date) (reward)

_____ _____ _____
(minigoal 2) (date) (reward)

_____ _____ _____
(minigoal 3) (date) (reward)

D. My program will include the addition of physical activity to my daily routine (such as walking to class):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

(over)

E. I will use the following tools to monitor my program and my progress toward my goals:

_____

(list any charts, graphs, or journals you plan to use)

_____

I sign this contract as an indication of my personal commitment to reach my goal.

_____ _____

(your signature) (date)

I have recruited a helper who will witness my contract and _____

_____

(list any way your helper will participate in your program)

_____ _____

(witness's signature) (date)

INTERNET ACTIVITY

Use a search engine to locate Web sites that relate to the cardiorespiratory endurance activity you've chosen for your fitness program.

How many total sites did the search engine locate relating to your activity? _____

Find at least two helpful sites and provide a brief description of each. Look for information that will help you safely enjoy the activity you've chosen.

Activity: _____

Site 1 (URL): _____

Description:

Site 2 (URL): _____

Description:

About how many sites did you have to visit before locating two useful ones? _____

Describe the overall list of sites. Were they mostly commercial, sponsored by people or businesses selling products related to the activity, or were there many sites sponsored by individuals and organizations?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 75

Getting to Know Your Fitness Facility

To help create a successful training program, take time out to learn more about a fitness facility on your campus or in your community.

Basic Information

Name and location of facility: _____

Hours of operation: _____

Times available for general use: _____

Times most convenient for your schedule: _____

Can you obtain an initial session or consultation with a trainer to help you create a program? ____ yes ____ no

If so, what does the initial planning session involve? _____

_____

Are any of the staff certified? Do any have special training? If yes, list/describe: _____

_____

What types of weight training equipment are available for use? _____

_____

Are other types of equipment available, such as treadmills or stair-climbers for the development of cardiorespiratory endurance? If so, briefly list/describe: _____

_____

_____

Are any group activities or classes available? If so, briefly describe: _____

_____

_____

Yes	**No**	
____	____	Is there a fee for using the facility? If so, how much? $_____
____	____	Is a student ID required for access to the facility?
____	____	Do you need to sign up in advance to use the facility or any of the equipment?
____	____	Is there typically a line or wait to use the equipment during the times you use the facility?
____	____	Is there a separate area with mats for stretching and/or cool-down?
____	____	Do you need to bring your own towel?
____	____	Are lockers available? If so, do you need to bring your own lock? ____ yes ____ no
____	____	Are showers available? If so, do you need to bring your own soap/shampoo? ____ yes ____ no
____	____	Is drinking water available? (If not, be sure to bring your own bottle of water.)

Describe any other amenities, such as vending machines or saunas, that are available at the facility:

_____

_____

(over)

Information About Equipment

Find out more about the specific weight training equipment available at your local fitness facility, and use this information to help create a specific strength training program. Fill in the equipment and exercise(s) you can use to develop each of the following major muscles and muscle groups; for example, the muscles in the upper back can be worked by doing lat pulls on a lat pull machine or station. In many instances, one exercise can be used to develop several muscles. If you would like to incorporate additional exercises for other muscles, list those in the bottom portion of the chart. (Information about the equipment, exercises, and muscles worked may be available in writing near each piece of equipment and/or from the facility's staff.)

Muscles and muscle groups	**Equipment**	**Exercise(s)**
Chest		
Shoulders		
Upper back		
Front of the arms (biceps)		
Back of the arms (triceps)		
Buttocks		
Front of thighs (quadriceps)		
Back of thighs (hamstrings)		
Calves		
Abdomen		
Lower back		
Neck		

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 76

Body Image

Assessing Your Body Image

	Never	Sometimes	Often	Always
1. I dislike seeing myself in mirrors.	0	1	2	3
2. When I shop for clothing, I am more aware of my weight problem, and consequently I find shopping for clothes somewhat unpleasant.	0	1	2	3
3. I'm ashamed to be seen in public.	0	1	2	3
4. I prefer to avoid engaging in sports or public exercise because of my appearance.	0	1	2	3
5. I feel somewhat embarrassed by my body in the presence of someone of the other sex.	0	1	2	3
6. I think my body is ugly.	0	1	2	3
7. I feel that other people must think my body is unattractive.	0	1	2	3
8. I feel that my family or friends may be embarrassed to be seen with me.	0	1	2	3
9. I find myself comparing myself with other people to see if they are heavier than I am.	0	1	2	3
10. I find it difficult to enjoy activities because I am self-conscious about my physical appearance.	0	1	2	3
11. Feeling guilty about my weight problem preoccupies most of my thinking.	0	1	2	3
12. My thoughts about my body and physical appearance are negative and self-critical.	0	1	2	3

Now, add up the number of points you have circled in each column: _____ _____ + _____ + _____

Score Interpretation

The lowest possible score is 0, and this indicates a positive body image. The highest possible score is 36, and this indicates an unhealthy body image. A score higher than 14 suggests a need to develop a healthier body image.

(over)

In the space provided, draw (1) your body and (2) your perception of an ideal body of a person of your gender. If your drawing skills are limited, provide written descriptions.

(1) My body

(2) My idea of the ideal body

What differences do you see between your drawing/description of your own body and that of your ideal?

Where do your ideas about an ideal body come from?

List five positive things about your body:

1. _____
2. _____
3. _____
4. _____
5. _____

SOURCE: Questionnaire from Nash, J. D. 1986. *Maximize Your Body Potential.* Palo Alto, Calif.: Bull Publishing. Reprinted with permission from Bull Publishing Company.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 77

What Triggers Your Eating?

This test is designed to provide you with a score for five factors that describe many people's eating. This information will put you in a better position to manage your eating behavior and control your weight. Circle the number that indicates to what degree each situation is likely to make you start eating.

Social	**Very Unlikely**									**Very Likely**
1. Arguing or having a conflict with someone	1	2	3	4	5	6	7	8	9	10
2. Being with others when they are eating	1	2	3	4	5	6	7	8	9	10
3. Being urged to eat by someone else	1	2	3	4	5	6	7	8	9	10
4. Feeling inadequate around others	1	2	3	4	5	6	7	8	9	10
Emotional										
5. Feeling bad, such as being anxious or depressed	1	2	3	4	5	6	7	8	9	10
6. Feeling good, happy, or relaxed	1	2	3	4	5	6	7	8	9	10
7. Feeling bored or having time on my hands	1	2	3	4	5	6	7	8	9	10
8. Feeling stressed or excited	1	2	3	4	5	6	7	8	9	10
Situational										
9. Seeing an advertisement for food or eating	1	2	3	4	5	6	7	8	9	10
10. Passing by a bakery, cookie shop, or other enticement to eat	1	2	3	4	5	6	7	8	9	10
11. Being involved in a party, celebration, or special occasion	1	2	3	4	5	6	7	8	9	10
12. Eating out	1	2	3	4	5	6	7	8	9	10
Thinking										
13. Making excuses to myself about why it's OK to eat	1	2	3	4	5	6	7	8	9	10
14. Berating myself for being so fat or unable to control my eating	1	2	3	4	5	6	7	8	9	10
15. Worrying about others or about difficulties I am having	1	2	3	4	5	6	7	8	9	10
16. Thinking about how things should or shouldn't be	1	2	3	4	5	6	7	8	9	10
Physiological										
17. Experiencing pain or physical discomfort	1	2	3	4	5	6	7	8	9	10
18. Experiencing trembling, headache, or light-headedness associated with not eating or too much caffeine	1	2	3	4	5	6	7	8	9	10
19. Experiencing fatigue or feeling overtired	1	2	3	4	5	6	7	8	9	10
20. Experiencing hunger pangs or urges to eat, even though I've eaten recently	1	2	3	4	5	6	7	8	9	10

(over)

Scoring

Total your scores for each category, and enter them below. Then rank the scores by marking the highest score 1, next highest score 2, and so on. Focus on the highest ranked categories first, but any score above 24 is high and indicates that you need to work on that category.

Category	Total Score	Rank Order
Social (Items 1–4)	_____	_____
Emotional (Items 5–8)	_____	_____
Situational (Items 9–12)	_____	_____
Thinking (Items 13–16)	_____	_____
Physiological (Items 17–20)	_____	_____

What Your Score Means

Social A high score here means you are very susceptible to the influence of others. Work on better ways to communicate more assertively, handle conflict, and manage anger. Challenge your beliefs about the need to be polite and the obligations you feel you must fulfill.

Emotional A high score here means you need to develop effective ways to cope with emotions. Work on developing skills in stress management, time management, and communication. Practicing positive but realistic self-talk can help you handle small daily upsets.

Situational A high score here means you are especially susceptible to external influences. Try to avoid external cues to eat and respond differently to those you cannot avoid. Control your environment by changing the way you buy, store, cook, and serve food. Anticipate potential problems, and have a plan for handling them.

Thinking A high score here means that the way you think—how you talk to yourself, the beliefs you hold, your memories, and your expectations—have a powerful influence on your eating habits. Try to be less self-critical, less perfectionistic, and more flexible in your ideas about the way things ought to be. Recognize when you're making excuses or rationalizations that allow you to eat.

Physiological A high score here means that the way you eat, what you eat, or medications you are taking may be affecting your eating behavior. You may be eating to reduce physical arousal or deal with physical discomfort. Try eating three meals a day, supplemented with regular snacks if needed. Avoid too much caffeine. If any medication you're taking produces adverse physical reactions, switch to an alternative, if possible. If your medications may be affecting your hormone levels, discuss possible alternatives with your physician.

SOURCE: Adapted from Nash, J. D. 1997. *The New Maximize Your Body Potential.* Palo Alto, Calif.: Bull Publishing. Reprinted with permission from Bull Publishing Company.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 78

Do You Feel Social Pressure to Eat?

This quiz can help assess how well you cope with social influences on your eating behavior. Rate yourself on each of the following statements according to how much you agree or disagree with each one.

	Strongly disagree				**Strongly agree**
1. It's not right to say no when someone is just trying to be nice to me.	1	2	3	4	5
2. It isn't polite to refuse food when someone has prepared it especially for me.	1	2	3	4	5
3. It's often hard for me to speak up for what I need or want.	1	2	3	4	5
4. I'd rather put my own needs second than hurt someone else's feelings.	1	2	3	4	5
5. It isn't fair to want others to help me in my weight-management efforts.	1	2	3	4	5
6. I shouldn't involve others in my problems.	1	2	3	4	5
7. I need to order drinks or a "big" entree at a restaurant in order to make others feel comfortable.	1	2	3	4	5
8. When someone else is paying for it, I feel I may as well take advantage.	1	2	3	4	5
9. Guests who are invited to dinner expect to be treated to fancy (which generally means "high-calorie") meals.	1	2	3	4	5
10. A good host or hostess fixes special meals for company, and this usually involves a high-fat entree and perhaps a sugary dessert.	1	2	3	4	5
11. When invited to dinner, I should show my appreciation by eating well.	1	2	3	4	5
12. Calling ahead to inquire about the menu or making special requests of a hostess is making a nuisance of myself and I shouldn't do it.	1	2	3	4	5
13. Other people depend on me, and their needs come first.	1	2	3	4	5
14. When someone tries to pressure me, I resist, even if what they want me to do is a good idea.	1	2	3	4	5
15. When someone I care about doesn't want me to change, I feel I should do as they ask.	1	2	3	4	5
16. I like the sympathy and attention I get from having a weight problem.	1	2	3	4	5
17. When I see others eating, I just can't resist getting something to eat, too.	1	2	3	4	5
18. I can't resist food at parties and celebrations.	1	2	3	4	5
	___ +	___ +	___ +	___ +	___
Total score			= _____		

Score interpretation

54–90: *High Pressure Quotient* Much of your belief system makes it harder for you to cope with social influences. You need to challenge your beliefs and make changes in the way you think.

37–53: *Moderate Pressure Quotient* Some of your beliefs make it difficult for you to cope with social influences. Identify which beliefs keep you stuck, and change your way of thinking on these.

18–36: *Low Pressure Quotient* Your beliefs stand you in good stead to resist social influences.

SOURCE: Nash, J. D. 1997. *The New Maximize Your Body Potential.* Palo Alto, Calif.: Bull Publishing. Reprinted by permission of the publisher.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 79

Getting Started on a Weight-Loss Program

Part I. Identifying Reasons for Losing Weight

If you have decided that you want to lose weight, establishing your personal reasons for this decision will help you remain committed to your program. Check the reasons listed below that are important to your decision. If your most important reasons aren't included, add them to the list.

	Important	Ranking
1. Follow my doctor's advice.	____	____
2. Wear a smaller clothing size.	____	____
3. Improve my appearance.	____	____
4. Feel more assured and attractive.	____	____
5. Feel healthier and more in control of myself.	____	____
6. Firm up muscle tone.	____	____
7. Improve sports performance.	____	____
8. Please someone who is important to me.	____	____
9. Help reduce low-back pain.	____	____
10. Lower high blood pressure.	____	____
11. Lower cholesterol and/or triglyceride levels.	____	____
12. Increase high-density lipoprotein cholesterol.	____	____
13. Help control diabetes.	____	____
14. Have more energy and increase stamina.	____	____
15. Reduce risk of circulatory disease.	____	____
16. _____	____	____
17. _____	____	____
18. _____	____	____

Next, assign a ranking (1 is most important, 2 is next) to each of the reasons you have identified. For your top two reasons, write out below why these are your most important reasons. Do you think these reasons will help motivate you to start and stick with a weight-loss program? Why? Can you develop any strategies for using these reasons in your program (e.g., as rewards or written out and taped to the refrigerator as reminders)?

(over)

Part II. Daily Food Journal

To take a critical look at your eating habits, complete this food journal:

Date: _____ Day: M Tu W Th F Sa Su

Time of day	M/S	Food eaten	Cals.	H	Where did you eat?	What else were you doing?	How did someone else influence you?	What made you want to eat what you did?	Emotions, thoughts, and feelings

M/S = Meal or Snack H = Hunger Rating (0–3)

(over)

Part III. Identifying and Developing Strategies for Managing Common Eating Problems

By analyzing your daily food journal, you should be able to identify patterns of behavior that can contribute to overeating. For each of the groups of statements that appear below, check those that are true for you. If you check several statements for a given pattern/problem, it will probably be a significant factor in your weight-control program. Possible strategies for dealing with each type of problem are given. For those eating problems you identify as important, add your own ideas to the strategies listed.

A.

____ I often skip meals.

____ I often eat a number of snacks in place of a meal.

____ I don't have a regular schedule of meal and snack times.

____ I make up for missed meals and snacks by eating more at the next meal.

Problem: Irregular eating habits

Possible solutions:

1. Write out a plan for each day's meals in advance. Carry it with you and stick to it.
2. _____
   _____
3. _____
   _____

B.

____ I eat more than one sweet dessert or snack each day.

____ I usually snack on foods high in calories and fat (chips, cookies, ice cream).

____ I drink regular (not sugar-free) soft drinks.

____ I choose types of meat that are high in fat.

____ I consume more than one alcoholic beverage each day.

Problem: Poor food choices

Possible solutions:

1. Keep a supply of raw vegetables handy for snacks.
2. _____
   _____
3. _____
   _____

C.

____ I always eat everything on my plate.

____ I often go back for seconds and thirds.

____ I take larger helpings than most people.

____ I eat up leftovers instead of putting them away.

(over)

Problem: Portion sizes too large

Possible solutions:

1. Measure all portions with a scale or measuring cup.
2. _____
   _____
3. _____
   _____

D.

____ I read or watch TV when I eat.

____ I eat more or snack when I'm with a certain group of people.

____ I always grab a snack between classes or when I walk through the kitchen.

____ I buy a cookie or doughnut every time I walk by the student union.

Problem: Environmental cues trigger eating

Possible solutions:

1. Eat only in one place and do nothing else while eating.
2. _____
   _____
3. _____
   _____

E.

____ I tend to eat more when there's too much work to do.

____ Eating has a soothing effect when I'm troubled.

____ I like to eat when I'm lonely, frustrated, or anxious.

____ I'm liable to eat more if I'm annoyed after a bad morning or a bad day.

Problem: Food used to replace or deal with feelings

Possible solutions:

1. If you have a lot of work to do, stop and make a schedule for finishing it.
2. _____
   _____
3. _____
   _____

Did you discover any other patterns from your food journal that are contributing to overeating? If so, describe them below and give possible strategies for changing them.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 80

Identifying Weight-Loss Goals and Ways to Meet Them

Part I. Calculate and Rate Your Current Body Mass Index and Waist Circumference

1. **BMI:** Determine your BMI by referring to Figure 14.3 (Figure 11.3 in the brief version), or calculate it more precisely by dividing your body weight (in kilograms) by the square of your height (in meters). To convert, divide your weight in pounds by 2.2 to get kilograms, and multiply your height in inches by 0.0254 to get meters. For example, if you are 5 feet, 3 inches tall (63 inches) and weigh 130 pounds, you would calculate BMI as follows.

EXAMPLE:

$$\text{BMI} = \frac{(130 \div 2.2)}{(63 \times 0.0254)^2} = \frac{59.1}{(1.6)^2} = 23.0$$

YOUR BMI:

$$\text{BMI} = \frac{(\_\_\_\_ \text{ lb} \div 2.2)}{(\_\_\_\_ \text{ in} \times 0.0254)^2} = \frac{\_\_\_\_}{(\_\_\_\_)^2} = \_\_\_\_\_$$

Then, refer to Figure 14.3 in your text (Figure 11.3 in the brief version) for the appropriate rating of your BMI.

BMI: _____ Rating: _____

2. **Waist circumference:** To determine your waist circumference, measure your waist at its smallest point; if you don't have a natural waist, measure at the level of your navel. The cutoff points for increased risk of health problems are waist measurements of more than 40 inches for men and 35 inches for women; if your waist measurement exceeds the cutoff, put a check on the line below.

Waist circumference: ____ High risk? (✓) ____

Part II. Calculate a Target Body Weight

If the results of Part I indicate that a change in your BMI might be appropriate, you can calculate a target body weight based on a target BMI. Choose a target BMI; be sure that your choice is both healthy and realistic for you. Then complete the following calculations to determine your target body weight (in pounds).

Target BMI: _____

1. Convert your height measurement to meters by multiplying your height in inches by 0.0254.
   Height _____ in. × 0.0254 m/in. = height _____ m
2. Square your height measurement from step 1.
   Result from step 1 _____ m × result from step 1 _____ m = height _____ m^2
3. Multiply your target BMI by your height in meters, squared (the result from step 2) to get your target weight in kilograms.
   Target BMI _____ × result from step 2 _____ = target weight _____ kg
4. Multiply your target weight in kilograms by 2.2 to get your target weight in pounds.
   Target weight _____ kg × 2.2 lb/kg = target body weight _____ lb

For example, if you are 66 inches tall with a target BMI of 24.5, you would calculate target weight as follows:

66 in. × 0.0254 m/in. = 1.676 m

1.676 m × 1.676 m = 2.81 m^2

24.5 kg/m^2 × 2.81 m^2 = 68.8 kg

68.8 kg × 2.2 lb/kg = 151 lb

(over)

Part III. Identify Negative Calorie Balance Goals

Be realistic in your assessment of the number of pounds you can lose each week; a 1/2–2 pound loss per week is the most successful level for long-term weight loss.

1. _____ (Current weight) − _____ (Target weight) = _____ (Pounds to lose)
2. _____ (Total pounds to lose) ÷ _____ (Pounds to lose each week) = _____ (Number of weeks to achieve target weight)
3. _____ (Pounds to lose each week) × 3500 calories/pound = _____ (Negative calorie balance to achieve each week)
4. _____ (Negative calorie balance to achieve each week) ÷ 7 days/week = _____ (Negative calorie balance to achieve each day)

Part IV. Achieve Negative Calorie Balance Goals

To keep your weight-loss program schedule, you must achieve the daily negative calorie balance either by increasing your calorie expenditure (being more active) or by decreasing your calorie consumption (eating less). You may find that some combination of the two strategies will be the most successful.

Daily negative calorie balance (from Part III):_____

Changes in Activity Level

Adding a few minutes of exercise every day can be a fun and interesting way of expending calories. Use the calorie values for different activities listed in Table 13.3 in your text (main text only) to plan ways to raise your calorie expenditure level.

Activity	**Duration**	**Calories used**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	Total calories used	_____

Changes in Diet

Look closely at your daily food record (Wellness Worksheet 60). Identify ways to cut calorie consumption by eliminating certain items or substituting lower-calorie choices. Be realistic in your cuts and substitutions; you need to develop a plan you can stick with.

Food item	**Substitute food item**	**Calorie savings**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
	Total calories saved	_____

Total calories used _____ + Total calories saved _____ = _____

Have you met your required negative energy balance? If not, revise your dietary and activity changes to meet your goal.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 81

Using Food Labels in Weight Management

Food labels can be an important tool in weight management by helping you make more informed food choices. In general, you want to favor foods that are relatively high in the nutrients you'd like to consume more of, such as fiber and vitamins, and relatively low in calories and nutrients such as fat of which you'd like to limit your consumption. To complete this worksheet, choose three packaged foods to evaluate:

Item 1: _____

Item 2: _____

Item 3: _____

Part I. Nutrient Content Claims

Look first at the front of the food packages to see if they contain any nutrient content claims. The following claims may be associated with foods that can help with weight management; check any that appear.

Item 1	Item 2	Item 3	
_____	_____	_____	Healthy *(a food that is low in total fat, low in saturated and trans fat, has no more than 360–480 mg of sodium and 60 mg of cholesterol, and provides 10% or more of the Daily Value for vitamin A, vitamin C, protein, calcium, iron, or dietary fiber)*

Claims relating to calories, fat, and other substances you might limit for weight management:

_____	_____	_____	Light or lite *(one-third fewer calories or 50% less fat than a similar product)*
_____	_____	_____	Low calorie *(40 calories or less per serving)*
_____	_____	_____	Reduced calorie *(at least 25% fewer calories than a similar product)*
_____	_____	_____	Fat-free *(less than 0.5 g of fat per serving)*
_____	_____	_____	Low-fat *(3 g of fat or less per serving)*
_____	_____	_____	Reduced fat *(at least 25% less fat than a similar product)*
_____	_____	_____	Lean *(cooked seafood, meat, or poultry with less than 10 g of fat, 4.5 g of saturated fat, and 95 mg of cholesterol per serving)*
_____	_____	_____	Extra lean *(cooked seafood, meat, or poultry with less than 5 g of fat, 2 g of saturated fat, and 95 mg of cholesterol per serving)*
_____	_____	_____	Sugar-free *(less than 0.5 g of sugar per serving)*
_____	_____	_____	Reduced sugar *(at least 25% less sugar than a similar product)*

Claims relating to fiber, vitamins, and other substances you might favor for weight management:

_____	_____	_____	High, rich in, or excellent source of *(20% or more of the Daily Value for a particular nutrient)*
_____	_____	_____	Good source of *(10–19% of the Daily Value for a particular nutrient)*
_____	_____	_____	Extra or added *(10% more of the Daily Value per serving when compared to a similar product)*
_____	_____	_____	High fiber *(5 g or more per serving)*
_____	_____	_____	Good source of fiber *(2.5–4.9 g per serving)*
_____	_____	_____	More or added fiber *(at least 2.5 g more per serving than a similar product)*

(over)

Part II. The Nutrition Facts Panel

Take a closer look at the Nutrition Facts panels of the foods you've chosen to evaluate, and fill in the information below. If your typical serving size is larger than the standard serving size listed on the label, adjust the nutrient values accordingly. (For example, if the serving size on the label is four crackers and you typically eat eight crackers, multiply all the values on the label by two.) If additional vitamins and minerals appear on the Nutrition Facts panels of one or more of the foods you've selected, list them under "other."

	Item 1	Item 2	Item 3
Serving size on label			
Your typical serving size			
Calories	calories	calories	calories
Total fat	grams	grams	grams
Dietary fiber	grams	grams	grams
Sugars	grams	grams	grams
Vitamin A	% DV	% DV	% DV
Vitamin C	% DV	% DV	% DV
Calcium	% DV	% DV	% DV
Iron	% DV	% DV	% DV
Other:			
Other:			
Other:			
Other:			

Next, calculate what percentage of each food's total calories come from fat and sugar.

Item 1: (_____ × 9) + (_____ × 4) = _____ ÷ _____ = _____% of calories from fat and sugar
(grams of fat; grams of sugar; total calories)

Item 2: (_____ × 9) + (_____ × 4) = _____ ÷ _____ = _____% of calories from fat and sugar
(grams of fat; grams of sugar; total calories)

Item 3: (_____ × 9) + (_____ × 4) = _____ ÷ _____ = _____% of calories from fat and sugar
(grams of fat; grams of sugar; total calories)

Finally, think about how each of the foods you've chosen would fit into your overall daily diet. Ask yourself the following questions ("Yes" answers may indicate a food that should be limited by people for whom weight management is a concern):

	Item 1		Item 2		Item 3	
	Yes	No	Yes	No	Yes	No
Is my typical serving size much larger than the label serving size?						
Does the food have a high energy density—that is, many calories in a relatively small amount of food?						
Is the food high in fat and/or sugar?						
Is the food low in fiber?						
Is the food low in vitamins and minerals?						

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 82

Checklist for Evaluating Weight-Loss Books

Many weight-loss books on the market advocate ineffective or unsafe strategies for losing weight. Choose a diet book and evaluate the plan it advocates by answering the following questions.

Overall emphasis: What is the key emphasis or "hook" of the plan you are considering? Is it based on any research studies? If so, what type of studies were they? How long did the studies continue, and how many people participated? Were the studies published in a reputable journal?

Author credentials: Who is the author of the book? What is his or her education and experience relating to health and weight loss?

Overall dietary plan: Is a particular macronutrient distribution suggested? Are certain foods emphasized or severely limited? How does the basic dietary advice compare to the recommendations presented in your text?

Suggested energy intake: How many daily calories are recommended? Is it a reasonable energy intake for you? Would the energy intake recommendation represent a large cut in your daily intake?

Special costs: Does the plan recommend that you purchase any special foods, products, or supplements? If so, do the suggestions seem reasonable? What are the total costs involved? Does the plan include particular brands of foods and supplements rather than general dietary advice?

Physical activity: Does the book include a plan for increasing physical activity? If so, how does it compare with the activity recommendations in your text and with your current activity level?

(over)

Behavior change: Does the plan advocate changes in your diet and activity-related behavior? Is a complete behavior change plan provided?

Maintenance: How long does the plan presented in the book continue? Is advice provided for maintaining weight loss once you reach your goal?

Personal likes and dislikes: Does the plan appeal to you personally in its diet, activity, and behavior change recommendations? Does it seem like it would work for you given your daily routine and budget?

Red flags: Do advertisements for the book or the book itself contain any of the following red flags?

- Quick weight loss
- Weight loss without effort
- Use of expensive products
- Exaggerated claims of effectiveness or claims of being based on secret information or scientific breakthroughs
- Simplistic conclusions drawn from complex studies or recommendations based on a single study
- Very limited selection of foods
- Unbalanced eating plan that differs dramatically from the dietary advice offered by government agencies and major health organizations

Overall impressions: What are your overall impressions of the plan presented in the book? How does the advice in the book stack up against the advice in your text? What is your estimation of its overall safety and effectiveness?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 83

Checklist for Evaluating Weight-Loss Products and Services

Use this checklist to gather and compare information from any weight-loss programs you're considering. Make several copies of the blank form so you can fill out one for each program. A provider's willingness to give you this information is an important factor in choosing a program. If you need help to evaluate the information you gather, talk with your primary health care provider or a registered dietitian.

_____ _____
Program Name Web Site

_____
Address

_____

_____
Phone Number

In this program, my daily caloric intake will be: _____

My daily caloric intake is determined by: _____

I ☐ will ☐ will not be evaluated initially by program staff.

The evaluation will be made by (check all that apply):
☐ Physician ☐ Nurse ☐ Registered Dietitian ☐ Other company-trained employee

My progress is supervised by (check all that apply):
☐ Physician ☐ Nurse ☐ Licensed Psychologist
☐ Registered Dietitian ☐ Company-trained employee

I ☐ will ☐ will not be evaluated by a physician during the course of my treatment.

During the first month, my progress will be monitored:
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other _____

After the first month, my progress will be monitored:
☐ Weekly ☐ Biweekly ☐ Monthly ☐ Other _____

My weight-loss plan includes (check all that apply):
☐ Nutrition information about healthy eating
☐ Suggested menus and recipes
☐ Portion control
☐ Prepackaged meals
☐ Prescription weight-loss drugs
☐ Surgery
☐ At least 1200 calories/day for women or 1400 calories/day for men
☐ Keeping food diaries or other monitoring activities
☐ Liquid meal replacements
☐ Dietary supplements (vitamins, minerals, botanicals, herbals)
☐ Help with weight maintenance and lifestyle changes

(over)

My plan includes regular physical activity that is (check both if both apply):
☐ Supervised (at the program site) _____ times per week, _____ minutes per session.
☐ Unsupervised (on my own time) _____ times per week, _____ minutes per session.

The physical activity includes (check all that apply):
☐ Walking ☐ Swimming ☐ Stationary cycling
☐ Strength training ☐ Aerobic dancing ☐ Other _____

The weight-loss plan includes (check all that apply):
☐ Family counseling ☐ Group support ☐ Lifestyle modification advice
☐ Weight maintenance advice ☐ Weight maintenance counseling

☐ The staff explained the risks associated with this weight-loss program. They are:

_____

_____

_____

☐ The staff explained the costs of this program. (Check all that apply and fill in the blanks.)
☐ I will be charged a one-time entry fee of $ ____.
☐ I will be charged $ _____ per visit.
☐ Food replacements will cost about $ _____ per month.
☐ Prescription weight-loss drugs will cost about $ _____ per month.
☐ Vitamins and other dietary supplements will cost about $ _____ per month.
☐ Diagnostic tests are required and will cost about $ _____.
☐ Other costs include _____ at $ _____.

Total cost for this program $_____

The program gave me information about:
☐ The health risks of being overweight. ☐ The difficulty many people have maintaining weight loss.
☐ The health benefits of weight loss. ☐ How to improve my chances at maintaining my weight.

Other information to ask for:
☐ Participants in this program have lost an average of _____ lbs. over _____ months/years.
☐ Participants in this program have kept off _____ % of their weight loss for _____ year(s).

This information is based on the following (check one):
☐ All participants.
☐ Participants who completed the program.
☐ Other _____

Notes: _____

_____

_____

SOURCE: Federal Trade Commission and International Food Information Council Foundation. 2000. *Weight Loss: Finding a Weight Loss Program That Works for You*. Washington, D.C.: Federal Trade Commission. For the complete brochure and other resources, visit http://www.consumer.gov/weightloss.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 84

Diabetes Risk Assessment

Take this test to see if you are at risk for having diabetes. Diabetes is more common in African Americans, Latinos, Native Americans, Asian Americans, and Pacific Islanders. If you are a member of one of these ethnic groups, you need to pay special attention to this test.

Write in the points next to each statement that is true for you. If a statement is not true, put a zero. Then add your total score.

1. I am a woman who has had a baby weighing more than 9 pounds at birth.	**Yes**	**1**	____
2. I have a sister or brother with diabetes.	**Yes**	**1**	____
3. I have a parent with diabetes.	**Yes**	**1**	____
4. My weight is equal to or above that listed in the chart below.	**Yes**	**5**	____
5. I am under 65 years of age *and* I get little or no exercise.	**Yes**	**5**	____
6. I am between 45 and 64 years of age.	**Yes**	**5**	____
7. I am 65 years old or older.	**Yes**	**9**	____
	Total		____

Scoring 10 or more points:
You are at high risk for having diabetes. Only your health care provider can check to see if you have diabetes. See yours soon and find out for sure.

Scoring 3–9 points:
You are probably at low risk for having diabetes now. But don't just forget about it. Keep your risk low by losing weight if you are overweight, being active most days, and eating low-fat meals that are high in fruits and vegetables, and whole-grain foods.

At-Risk Weight Chart

If you weigh the same as or more than the amount listed for your height, you may be at risk for diabetes.

Height in feet and inches without shoes	Weight in pounds without clothing
4′ 10″	129
4′ 11″	133
5′ 0″	138
5′ 1″	143
5′ 2″	147
5′ 3″	152
5′ 4″	157
5′ 5″	162
5′ 6″	167
5′ 7″	172

Height in feet and inches without shoes	Weight in pounds without clothing
5′ 8″	177
5′ 9″	182
5′ 10″	188
5′ 11″	193
6′ 0″	199
6′ 1″	204
6′ 2″	210
6′ 3″	216
6′ 4″	221

(over)

INTERNET ACTIVITY

Lifestyle, especially diet and exercise habits, are critical in the management of diabetes. Use the Internet to investigate some of the ways in which people with diabetes can use diet and exercise to help successfully manage their condition. For example, you might investigate the general dietary recommendations for diabetics in terms of overall nutrient content, timing of meals, or some other factor. You might search for a recipe for a dish that you like that has been modified to make it appropriate for someone with diabetes. Or you might investigate any special exercise recommendations or considerations for people with diabetes. Choose one area to research, describe what you find, and compare the information with your own current lifestyle. What types of changes would you have to make if you were diagnosed with diabetes? Use one of the sites listed below, or do a search.

American Diabetes Association: http://www.diabetes.org
Canadian Diabetes Association: http://www.diabetes.ca
CDC's Diabetes Public Health Resource: http://www.cdc.gov/diabetes
Diabetes Action Research and Education Foundation: http://www.daref.org
NIDDK Diabetes Information: http://diabetes.niddk.nih.gov
Recipe Source: http://www.recipesource.com/special-diets/diabetic

Site(s) used (URL): _____

SOURCE: American Diabetes Association. 2005. *Could You Have Diabetes and Not Know It?* Copyright © 2010 American Diabetes Association. From http://www.diabetes.org. Reprinted with permission from The American Diabetes Association.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 85

Eating Disorder Checklist

For each statement, put a check in the column that best describes how often the statement is true for you.

Section One

Always 0	Very Often 0	Often 0	Some-times 1	Rarely 2	Never 3	
						1. I like eating with other people.
						2. I like my clothes to fit tightly.
						3. I enjoy eating meat.
						4. I have regular menstrual periods.
						5. I enjoy eating at restaurants.
						6. I enjoy trying new rich foods.

Section Two

Always 3	Very Often 2	Often 1	Some-times 0	Rarely 0	Never 0	
						7. I prepare foods for others but do not eat what I cook.
						8. I become anxious prior to eating.
						9. I am terrified about being overweight.
						10. I avoid eating when I am hungry.
						11. I find myself preoccupied with food.
						12. I have gone on eating binges where I feel that I may not be able to stop.
						13. I cut my food into small pieces.
						14. I am aware of the calorie content of foods that I eat.
						15. I particularly avoid foods with a high carbo-hydrate content (bread, potatoes, rice, etc.).
						16. I feel bloated after meals.
						17. I feel others would prefer if I ate more.
						18. I vomit after I have eaten.
						19. I feel extremely guilty after eating.

(over)

Always 3	Very Often 2	Often 1	Some-times 0	Rarely 0	Never 0	
						20. I am preoccupied with a desire to be thinner.
						21. I exercise strenuously to burn off calories.
						22. I weigh myself several times a day.
						23. I wake up early in the morning.
						24. I eat the same foods day after day.
						25. I think about burning up calories when I exercise.
						26. Other people think I am too thin.
						27. I am preoccupied with the thought of having fat on my body.
						28. I take longer than others to eat my meals.
						29. I take laxatives.
						30. I avoid foods with sugar in them.
						31. I eat diet foods.
						32. I feel that food controls my life.
						33. I display self-control around foods.
						34. I feel that others pressure me to eat.
						35. I give too much time and thought to food.
						36. I suffer from constipation.
						37. I feel uncomfortable after eating sweets.
						38. I engage in dieting behavior.
						39. I like my stomach to be empty.
						40. I have the impulse to vomit after meals.

Total your points (use the numbers given at the top of each column for the two sections).

Norms	Range (0–120 points)
Eating disorder	> 50 points
Borderline eating disorder	30–50 points
Normal*	< 30 points

*Average score among those with normal eating habits = 15.4.

SOURCE: Garner, D. M., M. Omstead, and J. Polivy. 1983. Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of Eating Disorders* 2:15–33. Copyright © 1983 John Wiley & Sons. Reprinted by permission of John Wiley & Sons, Inc.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 86

Facts About the Cardiovascular System

Review your knowledge of the cardiovascular system by filling in the blanks and answering the questions below. Refer to your textbook if necessary.

1. The cardiovascular system consists of the _____ and the blood vessels. Name and describe the three major types of blood vessels:

   a. _____

   _____

   b. _____

   _____

   c. _____

   _____

2. Name and define the two separate circulatory systems:

   a. _____

   _____

   b. _____

   _____

3. What changes occur when blood reaches the lungs?

   _____

   _____

4. About how much blood does each person have? _____

   How often does the total volume of blood circulate through the system? _____

5. How is the heart supplied with oxygenated blood?

   _____

   _____

6. Describe the electrical system that controls the heartbeat:

   _____

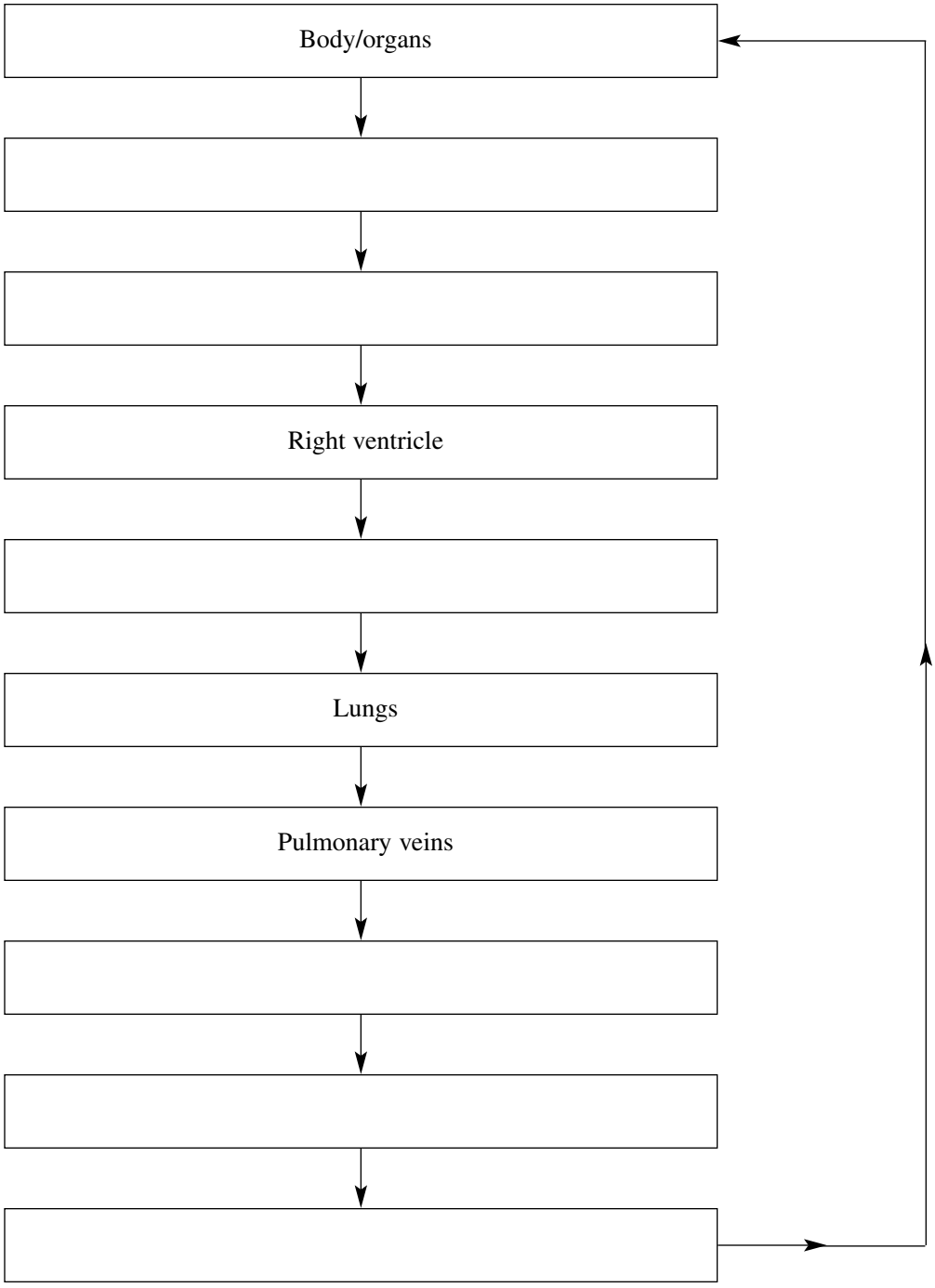
   _____

   _____

   _____

(over)

7. Trace the path of blood through the cardiorespiratory system by filling in the blanks:



Name _____ Section _____ Date _____

WELLNESS WORKSHEET 87

Screening for Heart Disease Risk Factors

It is important to begin managing risk factors for heart disease as soon as they develop—whether or not you actually have symptoms. The following guidelines can help ensure that you are appropriately screened.

Cholesterol: Fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides)

Who should be tested: Everyone age 20 and older, at least once every 5 years.

Result	Rating	Your result/rating
Total cholesterol (mg/dl)		_____
Less than 200	Desirable	
200–239	Borderline high	
240 or more	High	
LDL cholesterol (mg/dl)		_____
Less than 100	Optimal*	
100–129	Near optimal	
130–159	Borderline high	
160–189	High	
190 or more	Very high	
HDL cholesterol (mg/dl)		_____
Less than 40	Low	
60 or more	High (desirable)	
Triglycerides (mg/dl)		_____
Less than 150	Normal	
150–199	Borderline high	
200–499	High	
500 or more	Very high	

* For people at very high risk, an LDL goal of less than 70 mg/dl may be appropriate.

Actions:

To determine what actions to take based on your cholesterol results, first you need to count the number of the following five heart disease risk factors that apply to you:

(1) cigarette smoking
(2) hypertension (see next section)
(3) low HDL cholesterol (< 40 mg/dl)
(4) family history of heart disease
(5) age (45 years or older for men, 55 years or older for women).

An HDL level of 60 mg/dl or higher counts as a negative risk factor and removes one risk factor from the total count.

Number of personal risk factors: _____

(over)

Lower risk (if you have 0–1 risk factors):

- If your LDL < 160, retest within 5 years.
- If your LDL ≥ 160, initiate TLC (see below) and retest in 3 months; drug therapy may be recommended, especially if LDL is 190 or above.

If you have 2 or more risk factors:

The next step is to determine your 10-year risk of having a heart attack. To do this, complete the assessment on the final page of this worksheet or visit the online version of the assessment at http://hin.nhlbi.nih.gov/atpiii/calculator.asp?utertype=pub. Your score will be in the form of a percentage, the likelihood that you will have a heart attack within the next 10 years. Find the risk category below that corresponds to the number of risk factors you have and your 10-year risk of a heart attack.

Moderate risk (2 or more risk factors, 10-year risk < 10%):

- If your LDL is < 130, retest as suggested by physician.
- If your LDL is ≥ 130, initiate TLC (see below) and retest in 3 months; drug therapy may be recommended, especially if LDL is ≥ 160.

Moderately-high risk (2 or more risk factors, 10-year risk 10–20%):

- If your LDL is < 130, retest as suggested by physician; drug therapy may be recommended for some people with LDL of 100–129.
- If your LDL is ≥ 130, initiate TLC (see below) and retest in 3 months; drug therapy may be recommended for anyone in this group with LDL ≥ 130.

High-risk (Heart disease or a risk equivalent, 10-year risk > 20%):

Equivalent risk conditions include diabetes, peripheral vascular disease, abdominal aortic aneurysm, and carotid artery disease.

- If your LDL is < 100, initiate TLC (see below) and retest as suggested by physician.
- If your LDL is ≥ 100, initiate TLC (see below) and drug therapy, and retest as suggested by physician.

For some people at very high risk, an LDL goal of less than 70 is recommended, and drug therapy may be recommended to reach this goal. People at very high risk may include those who have had a recent heart attack or who have heart disease combined with either diabetes, poorly controlled risk factors (such as continued smoking), or metabolic syndrome.

TLC = Therapeutic Lifestyle Changes, including weight management, physical activity, and a diet that meets the following criteria:

- 25–35% of total calories as fat
- 7% or less of total calories as saturated fat
- Up to 10% of total calories as polyunsaturated fat
- Up to 20% of total calories as monounsaturated fat
- 50–60% of total calories as carbohydrate
- About 15% of total calories as protein
- 20–30 grams per day of dietary fiber
- Less than 200 mg per day of cholesterol

For some people the addition of plant stanols/sterols (2 grams per day) and increased soluble (viscous) fiber (10–25 grams/day) may be recommended.

(over)

Blood Pressure

Who should be tested: Everyone, at least once every 2 years.

Systolic (mm Hg)		Diastolic (mm Hg)	Rating	Your result/rating
below 120	and	below 80	Normal	_____
120–139	or	80–89	Prehypertension	
140–159	or	90–99	Stage 1 hypertension	
160 and above	or	100 and above	Stage 2 hypertension	

Actions:

- If your rating is normal, maintain a healthy lifestyle and retest in 2 years.
- If your rating is prehypertension, follow your physician's advice about lifestyle changes and retesting.
- If your rating is hypertension, follow your physician's advice about lifestyle changes, medication, and retesting. Stage 2 hypertension will likely require a two-drug combination to control.

Fasting Blood Sugar

Who should be tested: Everyone who has any of the following risk factors for diabetes should be tested at least every 3 years: age 45 or older, obesity, blood pressure over 139/89, HDL below 35, physical inactivity, ethnicity (Blacks, Latinos, American Indians, Asians, Pacific Islanders), triglycerides over 249, family history of diabetes, gestational diabetes, previous abnormal blood sugar test, or polycystic ovary syndrome.

Result	Rating	Your result/rating
Below 110 mg/dl	Normal	_____
110–125 mg/dl	Pre-diabetes	
126 mg/dl or higher	Diabetes	

Action: If your result indicates that you have pre-diabetes or diabetes, follow your physician's recommendations for lifestyle changes, medication, and future testing.

C-Reactive Protein (CRP)

Who should be tested: Everyone classified as at intermediate 10-year risk of having a heart attack. Take the 10-year risk test; if your risk is between 10% and 20%, your CRP level should be tested.

Result	Rating	Your result/rating
<1.0 mg/l	Low	_____
1.0–3.0 mg/l	Average	
>3.0 mg/l	High	

Action: If you have an elevated CRP level, follow your physician's advice for lifestyle changes and, if necessary, medication.

Metabolic Syndrome/Insulin Resistance Syndrome

Check if any of the following risk factors apply to you:

____ Abdominal obesity (waist circumference greater than 40 inches in men and 35 inches in women)
____ High blood pressure (130/85 or higher)
____ High triglycerides (150 mg/dl or higher)
____ Low HDL cholesterol (below 40 mg/dl in men and 50 mg/dl in women)
____ Insulin resistance (fasting glucose of 110 mg/dl or higher)

Number of metabolic syndrome risk factors: _____

You are classified as having metabolic syndrome if you have three or more of the risk factors associated with the condition. If you have metabolic syndrome, discuss lifestyle changes and other treatment options with your physician.

(over)

Determining 10-Year Risk for a Heart Attack

Use this score to help determine your goals for LDL cholesterol and the need for CRP testing.

Women

1 Age

Years	Points	Years	Points
20–34	–7	55–59	8
35–39	–3	60–64	10
40–44	0	65–69	12
45–49	3	70–74	14
50–54	6	75–79	16

2 Total Cholesterol

	Points				
(mg/dl)	Age 20–39	Age 40–49	Age 50–59	Age 60–69	Age 70–79
<160	0	0	0	0	0
160–199	4	3	2	1	1
200–239	8	6	4	2	1
240–279	11	8	5	3	2
≥280	13	10	7	4	2

3 Smoking

	Points				
	Age 20–39	Age 40–49	Age 50–59	Age 60–69	Age 70–79
Nonsmoker	0	0	0	0	0
Smoker	9	7	4	2	1

4 HDL

(mg/dl)	Points
≥60	–1
50–59	0
40–49	1
<40	2

5 Systolic Blood Pressure

(mm Hg)	If Untreated	If Treated
<120	0	0
120–129	1	3
130–139	2	4
140–159	3	5
≥160	4	6

Point Total	10-Year Risk (%)	Point Total	10-Year Risk (%)
<9	<1	17	5
9	1	18	6
10	1	19	8
11	1	20	11
12	1	21	14
13	2	22	17
14	2	23	22
15	3	24	27
16	4	≥25	≥30

Men

1 Age

Years	Points	Years	Points
20–34	–9	55–59	8
35–39	–4	60–64	10
40–44	0	65–69	11
45–49	3	70–74	12
50–54	6	75–79	13

2 Total Cholesterol

	Points				
(mg/dl)	Age 20–39	Age 40–49	Age 50–59	Age 60–69	Age 70–79
<160	0	0	0	0	0
160–199	4	3	2	1	0
200–239	7	5	3	1	0
240–279	9	6	4	2	1
≥280	11	8	5	3	1

3 Smoking

	Points				
	Age 20–39	Age 40–49	Age 50–59	Age 60–69	Age 70–79
Nonsmoker	0	0	0	0	0
Smoker	8	5	3	1	1

4 HDL

(mg/dl)	Points
≥60	–1
50–59	0
40–49	1
<40	2

5 Systolic Blood Pressure

(mm Hg)	If Untreated	If Treated
<120	0	0
120–129	0	1
130–139	1	2
140–159	1	2
≥160	2	3

Point Total	10-Year Risk (%)	Point Total	10-Year Risk (%)
<0	<1	9	5
0	1	10	6
1	1	11	8
2	1	12	10
3	1	13	12
4	1	14	16
5	2	15	20
6	2	16	25
7	3	≥17	≥30
8	4		

Your 10-year risk: _____

SOURCES: American Diabetes Association; American Heart Association; National Heart, Lung, and Blood Institute.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 88

Are You at Risk for Cardiovascular Disease?

Your chances of suffering an early heart attack or stroke depend on a variety of factors, many of which are under your control. The best time to identify your risk factors and change your behavior to lower your risk is when you are young. You can significantly affect your future health and quality of life if you adopt healthy behaviors. To help identify your risk factors, circle the response for each risk category that best describes you:

1. Gender and Age
   - 0 Female age 55 or younger; male age 45 or younger
   - 2 Female over age 55 or male over age 45

2. Heredity
   - 0 Neither parent suffered a heart attack or stroke before age 60.
   - 3 One parent suffered a heart attack or stroke before age 60.
   - 7 Both parents suffered a heart attack or stroke before age 60.

3. Smoking
   - 0 Never smoked
   - 3 Quit more than 2 years ago and lifetime smoking is less than 5 pack-years*
   - 6 Quit less than 2 years ago and/or lifetime smoking is greater than 5 pack-years*
   - 8 Smoke less than 1/2 pack per day
   - 13 Smoke more than 1/2 pack per day
   - 15 Smoke more than 1 pack per day

4. Environmental Tobacco Smoke
   - 0 Do not live or work with smokers
   - 2 Exposed to ETS at work
   - 3 Live with smoker
   - 4 Both live and work with smokers

5. Blood Pressure

   The average of the last three readings:
   - 0 120/80 or below
   - 1 121/81 to 130/85
   - 3 Don't know
   - 5 131/86 to 150/90
   - 9 l51/91 to 170/100
   - 13 Above 170/100

6. Total Cholesterol
   - 0 Lower than 190
   - 1 l90 to 210
   - 2 Don't know
   - 3 211 to 240
   - 4 241 to 270
   - 5 271 to 300
   - 6 Over 300

7. HDL Cholesterol

   The average of the last three readings:
   - 0 Over 60 mg/dl
   - 1 55 to 60
   - 2 Don't know HDL
   - 3 45 to 54
   - 5 35 to 44
   - 7 25 to 34
   - 12 Lower than 25

8. Exercise
   - 0 Exercise three times a week
   - 1 Exercise once or twice a week
   - 2 Occasional exercise less than once a week
   - 7 Rarely exercise

9. Diabetes
   - 0 No personal or family history
   - 2 One parent with diabetes
   - 6 Two parents with diabetes
   - 9 Non–insulin-dependent diabetes
   - 13 Insulin-dependent diabetes

10. Body Mass Index (kg/m^2)
    - 0 <23.0
    - 1 23.0–24.9
    - 2 25.0–28.9
    - 3 29.0–34.9
    - 5 35.0–39.9
    - 7 ≥ 40

11. Stress
    - 0 Relaxed most of the time
    - 1 Occasional stress and anger
    - 2 Frequently stressed and angry
    - 3 Usually stressed and angry

*Pack-years can be calculated by multiplying the number of packs you smoked per day by the number of years you smoked. For example, if you smoked a pack and a half a day for 5 years, you would have smoked the equivalent of $1.5 \times 5 = 7.5$ pack-years.

(over)

Scoring

Total your risk-factor points. Refer to the list below to get an approximate rating of your risk of suffering an early heart attack or stroke.

Score	Estimated Risk
Less than 20	Low risk
20–29	Moderate risk
30–45	High risk
Over 45	Extremely high risk

Whatever your score, examine your responses carefully to identify your CVD risk factors. Consider planning a behavior change strategy to lower your risk by changing your lifestyle.

INTERNET ACTIVITY

Use the World Wide Web to learn more about one of the controllable risk factors for cardiovascular disease. Choose one of the risk factors from the quiz in this worksheet—preferably one for which you have a high score. Find out more about the risk factor by visiting one of the sites listed in your text or by doing a Web search.

Risk factor: _____

Site(s) visited (URL): _____

What did you learn about the risk factor? Did you identify any strategies you can apply to your daily life? Any changes you can make in your current behavior to control or lessen the risk factor? List at least three practical strategies for reducing your risk:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 89

Facts About Cardiovascular Disease

Review your knowledge of CVD by filling in the blanks and answering the questions below. Refer to your textbook if necessary.

1. What are the six main risk factors for cardiovascular disease?

   a. _____ d. _____

   b. _____ e. _____

   c. _____ f. _____

2. List four additional factors that may increase risk for cardiovascular disease:

   a. _____ c. _____

   b. _____ d. _____

3. Name the two main forms of cholesterol and describe their function:

   a. _____

   _____

   b. _____

   _____

4. Describe the difference between systolic and diastolic pressure. Give normal and high ranges for each:

   _____

   _____

   _____

   Why is hypertension dangerous? _____

   _____

   _____

   List two treatments for hypertension:

   a. _____

   b. _____

5. What is atherosclerosis? How do plaques form, and why are they dangerous?

   _____

   _____

   _____

   _____

(over)

6. What is a heart attack? _____

_____

What is angina pectoris? _____

_____

What is arrhythmia, and how does it relate to sudden cardiac death? _____

_____

What are three early signals of a heart attack?

a. _____ c. _____

b. _____

List and describe two procedures performed to treat heart disease:

a. _____

_____

b. _____

_____

7. List and describe the two major types of strokes:

a. _____

_____

b. _____

_____

List three warning signs of a stroke:

a. _____ c. _____

b. _____

8. List and describe three other types of heart disease:

a. _____

_____

b. _____

_____

c. _____

_____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 90

Hostility Quiz and Log

Current research indicates that there are three aspects of hostility that are particularly harmful to health: cynicism (a mistrusting attitude regarding other people's motives), anger (an emotional response to other people's "unacceptable" behavior), and aggression (behaviors in response to negative emotions such as anger and irritation). To get an idea of how hostile you are, check any of the following statements that are true for you.

_____ 1. I often get annoyed at checkout cashiers or the people in front of me when I'm waiting in line.

_____ 2. I usually keep an eye on the people I work or live with to make sure they do what they should.

_____ 3. I often wonder how homeless people can have so little respect for themselves.

_____ 4. I believe that most people will take advantage of you if you let them.

_____ 5. The habits of friends or family members often annoy me.

_____ 6. When I'm stuck in traffic, I often start breathing faster and my heart pounds.

_____ 7. When I'm annoyed with people, I really want to let them know it.

_____ 8. If someone does me wrong, I want to get even.

_____ 9. I'd like to have the last word in any argument.

_____ 10. At least once a week, I have the urge to yell at or even hit someone.

Five or more "true" statements suggest that you're excessively hostile and should consider taking steps to mellow out.

If you are a hothead, try keeping a log of your hostile responses to people and situations (see over). Familiarize yourself with the patterns of thinking that lead to hostile feelings, and try to head them off before they develop into full-blown anger. If you feel your anger starting to build, ask yourself the following questions:

1. *Is this really important enough to get angry about?* For example, is having to wait an extra 5 minutes for a late bus so important that you should stew about it for the entire 15-minute ride?
2. *Am I really justified in getting angry?* Is the person in front of you really driving slowly, or are you trying to speed?
3. *Is getting angry going to make any real difference in this situation?* Will yelling and slamming the door really help your friend find the concert tickets he misplaced?

If you answer "yes" to all three questions, then you should calmly but assertively ask for what you want. A "no" to any question means that you should try to defuse your anger. Reason with yourself, distract your mind with another activity, or try one of the techniques for meditation or deep breathing described in Chapter 2 in your text. See Chapter 3 for additional anger management tips.

(over)

Hostility Journal Date: _____

Time	Location	What happened?	What were you thinking?	What were you feeling?	What did you do?

SOURCE: Quiz from Williams, V., and R. Williams. 1999. *Life Skills.* New York: Times Books. Used with permission of the authors.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 91

Facts About Cancer

Review your knowledge of cancer by answering the questions below. Refer to your textbook if necessary.

1. What is cancer?

_____

_____

_____

2. List and describe the two general types of tumors:

a. _____

_____

b. _____

_____

3. What is metastasis?

_____

_____

What are the two ways metastasis can occur?

a. _____

b. _____

4. List and define four common classes of malignant tumors:

a. _____

_____

b. _____

_____

c. _____

_____

d. _____

_____

(over)

5. What is a mutagen? How can gene mutation cause cancer?

_____

_____

_____

Give three examples of mutagens:

a. _____ c. _____

b. _____

6. What is a carcinogen?

_____

_____

Give three examples of carcinogens:

a. _____ c. _____

b. _____

7. Define the following, and describe how each can contribute to the development of cancer:

oncogene:_____

_____

suppressor gene: _____

_____

cancer promoter: _____

_____

8. List two dietary compounds that may contribute to cancer:

a. _____ b. _____

List six dietary compounds that may help prevent cancer:

a. _____ d. _____

b. _____ e. _____

c. _____ f. _____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 92

Cancer Risk Factors and Prevention

Part I. General Risk Factor Checklist

Are you doing all you can to avoid cancer? You can directly influence some risk factors, such as diet and exposure to cigarette smoke, while others are beyond your control. The following statements relate to factors that can put you at increased risk for cancer. To identify your risk factors, check any statements that are true for you.

____ I have a family history of cancer. (Check any of the following family members who have had cancer; list the type(s) and the age of the individual at diagnosis.)

- ____ Mother _____
- ____ Father _____
- ____ Sister _____
- ____ Brother _____
- ____ Paternal grandfather _____
- ____ Paternal grandmother _____
- ____ Maternal grandfather _____
- ____ Maternal grandmother _____

____ I use tobacco (any form).

____ I am constantly exposed to tobacco smoke at work or at home.

____ I live in a heavily polluted urban area.

____ I have frequently gotten blistering, peeling sunburns.

____ I am frequently exposed to sunlight and get a tan whenever possible.

____ I go to tanning salons or use a tanning lamp.

____ I have fair skin.

____ I have many moles.

____ I rarely use sunscreens.

____ I am overweight or obese.

____ I am sedentary.

____ I eat a diet that is rich in red meat and high in fat overall.

____ I eat a diet that is low in fiber overall.

____ I consume fewer than seven servings of fruits and vegetables per day.

____ I drink more than one (women) or two (men) alcoholic beverage(s) per day.

____ I have chronic hepatitis.

(over)

For Women Only (Check statements that are true for you; ignore those that are not applicable.)

____ I had early onset of menstruation.

____ My first pregnancy occurred after age 30.

____ I have HPV infection (genital warts).

____ I have genital herpes.

Part II. Assessing Your Risk for Specific Types of Cancer

Read the risk factors listed along the top of the chart. For any factor that applies to you, put a check in every unshaded box in its column. For the family history column, note any family member who has had the type of cancer listed at the left—record his or her relationship to you (uncle, brother, etc.) and age at diagnosis.

Risk Factors

Type of cancer	Smoking	Use of spit tobacco	Diet high in fat	Diet rich in meat	Diet low in fruits and vegetables	Little or no exercise	Obesity	Regular use of alcohol	Family history
Lung		■	■	■		■	■	■	
Colon and rectum	■	■						■	
Breast	■	■		■					
Prostate	■	■						■	
Stomach		■	■	■		■	■	■	
Esophagus			■	■		■	■		
Kidney		■	■	■	■	■		■	
Oral cavity			■	■		■	■		
Endometrium	■	■		■	■	■		■	
Larynx			■	■		■	■		

To determine your risk for a particular type of cancer, examine the number of corresponding risk factors you've checked. Strong family history may also increase your risk—the more relatives who have had a particular type of cancer, the closer their relationship to you, and the younger their age at diagnosis, the greater your risk. Use this chart to identify lifestyle behaviors that you can change to lower your risk of cancer.

(over)

SOURCE: Risk Profile adapted from Beating the odds: Best bets for cancer prevention. 1996. *Tufts University Diet and Nutrition Letter.* December. Copyright © 1996 *Tufts University Health and Nutrition Letter.* Reproduced with permission of Tufts University Health and Nutrition Letter.

Part III. Regular Self-Monitoring and Screening Tests

In addition to the factors mentioned in Parts I and II of this worksheet, early diagnosis is important. Use the following table of recommended cancer screening tests to complete this portion of the worksheet.

Screening Guidelines for the Early Dectection of Cancer in Average-risk Asymptomatic People

Cancer Site	Population	Test or Procedure	Frequency
Breast	Women, age 20+	Breast self-examination	Beginning in their early 20s, women should be told about the benefits and limitations of breast self-examination (BSE). The importance of prompt reporting of any new breast symptoms to a health professional should be emphasized. Women who choose to do BSE should receive instruction and have their technique reviewed on the occasion of a periodic health examination. It is acceptable for women to choose not to do BSE or to do BSE irregularly.
		Clinical breast examination	For women in their 20s and 30s, it is recommended that clinical breast examination (CBE) be part of a periodic health examination, preferably at least every three years. Asymptomatic women aged 40 and over should continue to receive a clinical breast examination as part of a periodic health examination, preferably annually.
		Mammography	Begin annual mammography at age 40.*
Colorectal†	Men and women, age 50+	*Tests that find polyps and cancer:* Flexible sigmoidoscopy,‡ or	Every five years, starting at age 50
		Colonoscopy, or	Every 10 years, starting at age 50
		Double-contrast barium enema (DCBE),‡ or	Every five years, starting at age 50
		CT colonography (virtual colonoscopy)‡	Every five years, starting at age 50
		Tests that mainly find cancer: Fecal occult blood test (FOBT) with at least 50% test sensitivity for cancer, or fecal immunochemical test (FIT) with at least 50% test sensitivity for cancer ‡ § or	Annual, starting at age 50
		Stool DNA test (sDNA)‡	Interval uncertain, starting at age 50
Prostate	Men, age 50+	Prostate-specific antigen test (PSA) with or without digital rectal exam (DRE)	Asymptomatic men who have at least a 10-year life expectancy should have an opportunity to make an informed decision with their health care provider about screening for prostate cancer after receiving information about the uncertainties, risks, and potential benefits associated with screening. Men at average risk should receive this information beginning at age 50. Men at higher risk, including African American men and men with a first degree relative (father or brother) diagnosed with prostate cancer before age 65, should receive this information beginning at age 45. Men at appreciably higher risk (multiple family members diagnosed with prostate cancer before age 65) should receive this information beginning at age 40.
Cervix	Women, age 18+	Pap test	Cervical cancer screening should begin approximately three years after a woman begins having vaginal intercourse, but no later than 21 years of age. Screening should be done every year with conventional Pap tests or every two years using liquid-based Pap tests. At or after age 30, women who have had three normal test results in a row may get screened every two to three years with cervical cytology (either conventional or liquid-based Pap test) alone, or every three years with an HPV DNA test plus cervical cytology. Women 70 years of age and older who have had three or more normal Pap tests and no abnormal Pap tests in the past 10 years and women who have had a total hysterectomy may choose to stop cervical cancer screening.
Endometrial	Women, at menopause	At the time of menopause, women at average risk should be informed about risks and symptoms of endometrial cancer and strongly encouraged to report any unexpected bleeding or spotting to their physicians.	
Cancer-related checkup	Men and women, age 20+	On the occasion of a periodic health examination, the cancer-related checkup should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.	

* Beginning at age 40, annual clinical breast examination should be performed prior to mammography.

†Individuals with a personal or family history of colorectal cancer or adenomas, inflammatory bowel disease, or high-risk genetic syndromes should continue to follow the most recent recommendations for individuals at increased or high risk.

‡ Colonoscopy should be done if test results are positive.

§ For FOBT or FIT used as a screening test, the take-home multiple sample method should be used. A FOBT or FIT done during a digital rectal exam in the doctor's office is not adequate for screening.

SOURCE: American Cancer Society. *Cancer Facts and Figures 2010.* Atlanta: American Cancer Society, Inc. Copyright © 2010 American Cancer Society, Inc. All rights reserved. Reprinted with permission.

Additional Recommended Self-Exams

- All men and women should perform a monthly skin self-exam to look for early signs of skin cancer. A skin examination by a physician is recommended as part of a cancer-related checkup.
- Men who choose to perform a testicular self-exam should do so once a month.

Read through the table and identify the screening tests that are appropriate for you. List these below, and then compare the recommended frequency with your actual frequency.

Test or procedure	Recommended frequency	Actual frequency

If your actual frequency is less than the recommended frequency, consider taking appropriate action. If necessary, make an appointment to see your physician or devise a behavior change plan for incorporating regular monthly self-exams for cancer into your routine; include strategies in your plan to help you remember to do your monthly self-exams and to keep yourself motivated.

INTERNET ACTIVITY

The World Wide Web has literally millions of sites that relate to cancer. Choose a particular type of cancer or a risk factor and use a search engine to find two helpful sites that provide information about it. You'll have better luck if you choose a specific topic such as "cervical cancer and HPV," "broccoli and cancer," or "testicular self-exam" rather than a more general one—"breast cancer," for example. Write a brief description of each site you locate.

Topic: _____

Site 1 (URL): _____

Description:

Site 2 (URL): _____

Description:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 93

Diet and Cancer

Your diet may include both cancer fighters and cancer promoters. Track your diet for 3 days, putting a mark ("1" for day 1, "2" for day 2, "3" for day 3) next to any food on either of the following lists that you eat.

Potential Cancer Fighters

Orange and yellow vegetables and (some) fruits
_____ apricots
_____ cantaloupe
_____ carrots
_____ mangoes
_____ papaya
_____ pumpkin
_____ red and yellow peppers
_____ sweet potatoes (yams)
_____ winter squash (acorn, butternut, banana, etc.)

Dark-green leafy vegetables
_____ beet greens
_____ broccoli rabe
_____ chard
_____ collard greens
_____ dandelion greens
_____ kale
_____ mustard greens
_____ romaine and other dark lettuces
_____ spinach
_____ turnip greens

Cruciferous vegetables
_____ bok choy
_____ broccoli
_____ brussels sprouts
_____ cabbage
_____ cauliflower
_____ kohlrabi
_____ turnips

Citrus fruits
_____ grapefruit
_____ lemon
_____ lime
_____ orange
_____ tangerine

Whole grains
_____ whole-grain bread, cereal, and pasta; brown rice; etc.

Legumes
_____ peas, lentils, and beans, including fava, navy, kidney, pinto, black, and lima beans

Other healthful choices
_____ apples
_____ asparagus
_____ berries (strawberries, raspberries, blueberries)
_____ chili peppers
_____ grapes
_____ green peppers
_____ honeydew melon
_____ kiwi fruit
_____ onions, garlic, leeks
_____ radishes
_____ soy products (tofu, tempeh, soy milk, miso, soybeans, etc.)
_____ sprouts (alfalfa, broccoli)
_____ tomatoes
_____ watermelon

Potential Cancer Promoters

Foods high in fat and saturated fat
_____ fatty meats, poultry with skin
list: _____
_____
_____ deep-fried foods
list: _____
_____
_____ whole milk and full-fat dairy products
list: _____
_____
_____ alcoholic beverages
_____ salt-cured, smoked, and nitrite-cured foods
_____ meats grilled, barbecued, or fried at high temperatures

(*Note:* Research is ongoing, and these lists of cancer fighters and cancer promoters are not comprehensive. However, these lists can provide a basis for assessing and improving your diet. Remember, nearly all fruits, vegetables, and grains are healthy, disease-fighting dietary choices.)

(over)

Analyze Your Diet

Review the list of cancer fighters. Foods in the first six categories should be eaten daily or nearly daily; the remainder are all good choices. Count the total number of servings of cancer fighters you consumed and the number of servings of the first six groups of foods.

_____ Total servings

_____ Servings from first six groups (orange and yellow vegetables and fruits, dark-green leafy vegetables, cruciferous vegetables, citrus fruits, whole grains, and legumes)

Select five additional cancer fighters from the list to try over the next few days. Fill the names of these five foods into the table below, along with your plan for incorporating them into your diet (as a side dish, on a salad, as a substitute for another food, etc.).

Next, review the foods you checked on the list of cancer promoters. For each, identify a healthier alternative or substitute food that you could choose. Fill this information into the table below.

Cancer Fighters to Try	Plan for Trying

Cancer Promoters to Eliminate	Substitute Food/Alternative Choice

Finally, put your plan for adding and substituting foods into action!

SOURCE: Fahey, T., P. Insel, and T. Roth. 2011. Lab 12-1 in *Fit & Well: Core Concepts and Labs in Physical Fitness and Wellness,* 9th ed. New York: McGraw-Hill. Copyright © 2011 The McGraw-Hill Companies. Reprinted with permission from The McGraw-Hill Companies.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 94

Skin Cancer Prevention

Part I. Skin Cancer Risk Assessment

Skin cancer is the most common cancer of all when cases of the highly curable forms are included in the count. Your risk of skin cancer from the ultraviolet radiation in sunlight depends on several factors. Take the quiz below to see how sensitive you are. The higher your UV-risk score, the greater your risk of skin cancer—and the greater your need to take precautions against too much sun.

Score 1 point for each true statement:

_____ 1. I have blond or red hair.
_____ 2. I have light-colored eyes (blue, gray, green).
_____ 3. I freckle easily.
_____ 4. I have many moles.
_____ 5. I had two or more blistering sunburns as a child.
_____ 6. I spent lots of time in a tropical climate as a child.
_____ 7. I have a family history of skin cancer.
_____ 8. I work outdoors.
_____ 9. I spend a lot of time in outdoor activities.
_____ 10. I like to spend as much time in the sun as I can.
_____ 11. I sometimes go to a tanning parlor or use a sunlamp.

_____ **Total score**

Score	Risk of skin cancer from UV radiation
0	Low
1–3	Moderate
4–7	High
8–11	Very high

Part II. Skin Cancer Prevention

Fill in the details for a recent or typical day in which you were outdoors in the sun for a significant period of time. Compare your typical behavior with the recommendations for skin cancer prevention.

Time of day: _____ Total duration of exposure: _____

Recommendation: Avoid exposure between 10 a.m. and 4 p.m.

UV index for the day: _____ (UV index ratings are usually available from the newspaper, the local weather bureau, or the NOAA Web site: http://www.epa.gov/sunwise/uvindex.html).

Recommendation: Take special care on days with a rating of 5 or more.

Clothing worn (describe): _____

_____

_____

_____

Recommendation: Wear long-sleeved shirts made of tightly woven cotton fabric, a wide-brimmed hat, and sunglasses with UV protection, and use a lip balm with UV protection.

(over)

Sunscreen used? (Y/N) _____ Type and SPF rating: _____

Recommendation: Use a broad-spectrum, water-resistant sunscreen with an SPF of 15 or higher. Look for sunscreens that contain ingredients that block both UVA and UVB rays.

Sunscreen applied _____ minutes before sun exposure.

Recommendation: Apply 30–45 minutes prior to sun exposure.

Amount of sunscreen applied: _____ ounces (Approximate by comparing the amount you applied with the amount in the full container.)

Recommendation: It takes about 1 ounce to cover an adult in a swimsuit. Many bottles or tubes of sunscreen contain a total of 4 ounces, so 1 ounce would be one-quarter of a typical bottle.

How did your behavior compare with the recommendations? The next time you plan to spend a day outdoors, use this worksheet to help maximize your cancer prevention behavior.

Part III. Skin Cancer Self-Exam

The American Cancer Society (ACS) recommends taking 5 to 10 minutes for a skin self-exam at least once a month. The best time to do a self-exam is usually after a bath or shower. Use a full-length mirror and a hand held mirror so that you can check your entire body for moles, blemishes, and birthmarks. The ACS recommends the following "Down and Back" procedure. Check off each step as you perform a self-exam.

_____1. While standing, examine your face, chest, and arms (both sides of the arms) and belly.

_____2. Then, sit down to look at the front surfaces of your legs and feet. Use the mirror to examine the backs of your legs and check out the soles of your feet.

_____3. Stand up again and use the mirror to inspect your buttocks and upper back. Use the hand mirror to examine the back of your neck and your scalp. Part your hair or use a blow dryer to lift your hair and give you a close look at your scalp.

The ACS advises you to become familiar with birthmarks, moles, and blemishes so that you know what they look like and can identify any changes in them. Signs to look for are changes in size, texture, shape, and color of blemishes or a sore that does not heal.

SOURCES: American Cancer Society. 2009. *Skin Cancer Prevention and Early Detection: Examining Your Skin* (http://www.cancer.org/docroot/PED/content/ped_7_1_Skin_Cancer_Detection_What_You_Can_Do.asp#Examining_your_skin; retrieved March 9, 2009); The Skin Cancer Foundation. 2009. *Self-Examination: How to Spot Skin Cancer* (http://www.skincancer.org/Self-Examination.html; retrieved March 9, 2009); American Academy of Dermatology. 2009. *Performing a Skin Self-Exam* (http://www.aad.org/public/exams/self.html; retrieved March 9, 2009).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 95

Performing an Oral Self-Exam

Performing regular oral self-exams may help spot early signs of oral cancer. Everyone should also have regular dental appointments that include an oral exam.

Who Is at Risk for Oral Cancer?

Key risk factors for oral cancer include tobacco use (any form, including cigarettes and spit tobacco), alcohol use, a past history and head and neck cancer, and exposure of the lips to the sun (without use of a lip balm containing sunscreen). The combination of tobacco use and alcohol use greatly increases the risk for oral cancer. Self-exams may be particularly important for people who use tobacco and/or alcohol.

Symptoms of Oral Cancer

The following are common symptoms of oral cancer:

- Patches inside your mouth or on your lips that are white, a mixture of red and white, or red
  - White patches (*leukoplakia*) are the most common. White patches sometimes become malignant.
  - Mixed red and white patches (*erythroleukoplakia*) are more likely than white patches to become malignant.
  - Red patches (*erythroplakia*) are brightly colored, smooth areas that often become malignant.
- A sore on your lip or in your mouth that won't heal
- Any swelling, thickening, lump, bump, or rough or eroded area
- Bleeding in your mouth
- Loose teeth
- Difficulty or pain when swallowing; feeling that something is stuck in the back of the throat
- A change in your bite, or difficulty wearing dentures
- Numbness or tenderness in the mouth, neck, face
- A lump in your neck
- An earache

Self-Exam

Thoroughly examine your mouth for the symptoms of oral cancer listed above. Use a light to get a better view. If you are a spit tobacco user, pay special attention to the area where you typically hold tobacco in your mouth.

- Look at your lips from the outside and then pull each one out to examine the inside surfaces. Feel for any lumps or bumps.
- Pull out and back on each of your cheeks and look at the inside surfaces.
- With upper and lower teeth touching, check the gums bordering the outside surfaces of your teeth.
- Open wide and check the inside gum surfaces; use a mirror to view the roof of your mouth and the upper inside gum surfaces.
- Run your finger across your gum surfaces and the inside of your cheeks to check for any bumps or other abnormalities.

(over)

- Stick out your tongue and examine the top; move it from side to side and lift it up in order to view all the surfaces. Feel your tongue for lumps.
- Check your teeth for looseness.
- Finally, feel your neck for any lumps or swellings.

Report any changes to your dentist or physician promptly; she or he can do a professional examination to further evaluate any symptoms. Keep a record of your exams, both self and professional. Note any findings.

Date of exam	Type (self or professional)	Notes

SOURCES: National Cancer Institute. 2004. *What You Need to Know About Oral Cancer* (http://www.cancer.gov/cancertopics/wyntk/oral/page1; retrieved January 12, 2011); Cleveland Clinic Health Information Center. 2008. *Oral Cancer* (http://my.clevelandclinic.org/disorders/oral_cancer/hic_oral_cancer.aspx; retrieved January 12, 2011).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 96

Facts About Pathogens and How They Cause Disease

Part I. Pathogens

Familiarize yourself with different types of pathogens by completing the chart below. Refer to your textbook if necessary.

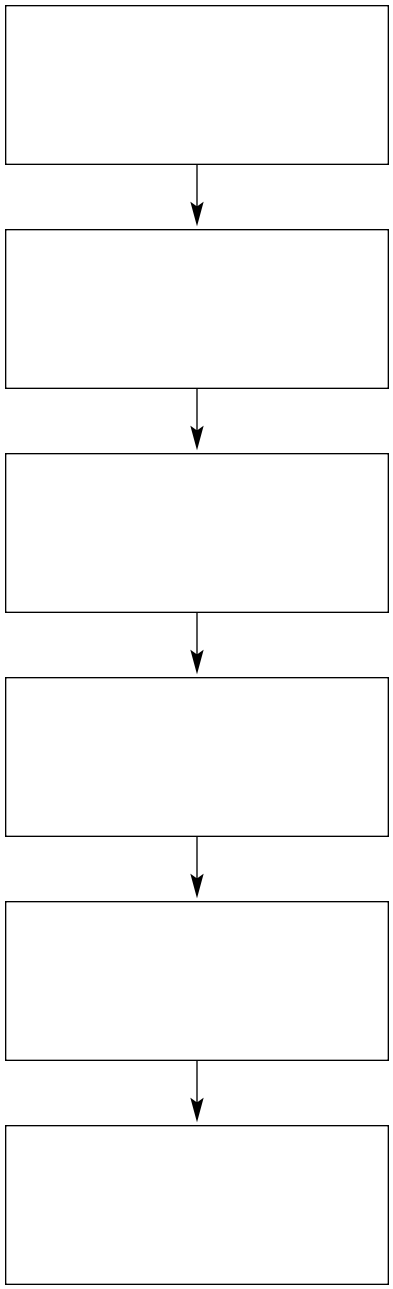
	Description and Examples	Diseases Caused	Possible Treatments
Bacteria			
Viruses			
Fungi			
Protozoa			
Parasitic worms			
Prions			

(over)

Part II. Chain of Infection

Fill in the steps in the chain of infection, and write a brief description of each step. List at least two ways that the chain can be broken at each step.

Chain of Infection **Description**



Name _____ Section _____ Date _____

WELLNESS WORKSHEET 97

Facts About the Body's Defenses Against Infection

Review your knowledge of infection and immunity by answering the questions below. Refer to your textbook if necessary.

1. List and describe three of the body's physical or chemical barriers against infection:

   a. _____

   b. _____

   c. _____

2. What general type of cells carry out the immune response? _____

   _____

   Where are these immune defenders produced? _____

   _____

   Describe each of the following types of cells and explain their role in the immune response:

   Neutrophils: _____

   _____

   Macrophages: _____

   _____

   Natural killer cells: _____

   _____

   Dendritic cells: _____

   _____

   Helper T cells: _____

   _____

   Killer T cells: _____

   _____

   Suppressor T cells: _____

   _____

   B cells: _____

   _____

   Memory T and B cells: _____

3. What are antibodies? What is their role in the immune response?

   _____

   _____

(over)

4. How do the body's defenders recognize an enemy? What is an antigen?

5. What is the inflammatory response?

6. Briefly describe the four phases of the immune response:

   a.

   b.

   c.

   d.

7. What is immunity? When and how does it occur?

8. When is an infected person contagious?

9. What is a vaccine?

   What are the two types of immunity that a vaccine can confer?

   a.

   b.

10. What is an allergic reaction and how does it occur?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 98

Checklist for Avoiding Infection

The best thing you can do to prevent an infection is to limit your exposure to pathogens. The next best thing is to keep your immune system as strong as possible. Read through the following list of statements and check whether each is mostly true or mostly false for you.

True **False**

Exposure to Pathogens

____ ____ I receive drinking water from a clean supply.

____ ____ The area in which I live has adequate sewage treatment.

____ ____ I frequently wash my hands with soap and warm water for at least 10–20 seconds.

____ ____ I avoid close contact with people who are infectious with diseases transmitted via the respiratory route (e.g., influenza, chicken pox, and tuberculosis).

____ ____ I do not inject drugs.

When Outdoors

____ ____ When hiking or camping, I do not drink water from streams, rivers, or lakes without first purifying it.

____ ____ I avoid contact with ticks, mosquitoes, rodents, bats, and other disease carriers.

____ ____ When hiking in the woods or playing in a yard in an area where Lyme disease or other tickborne infections have been reported, I take appropriate precautions:

- ____ Wear light-colored clothing: long pants, a long-sleeved shirt, and closed shoes.
- ____ Tuck my pants into my socks, shoes, or boots.
- ____ Tuck my shirt into my pants.
- ____ Wear light-colored, tightly woven fabrics.
- ____ Wear a hat.
- ____ Stay near the center of trails.
- ____ Check myself daily for ticks.
- ____ Shower and shampoo after each outing.
- ____ Wash clothes and check equipment after each outing.
- ____ Use an insect repellent containing DEET, picaridan, or oil of lemon eucalyptus on my skin and/or a spray containing permethrin on my clothing.

____ ____ If I discover a tick attached to my skin, I remove it immediately in an appropriate manner (fill in): _____

_____

_____

_____

(over)

True False

In a Sexual Relationship

____ ____ I am in a monogamous relationship with a mutually faithful, uninfected partner.

____ ____ I use condoms.

____ ____ I discuss STDs and prevention with new partners.

____ ____ I avoid engaging in high-risk behaviors with any person who might carry HIV.

In the Kitchen

____ ____ I wash my hands thoroughly with warm soapy water before and after handling food.

____ ____ I don't let groceries sit in a warm car.

____ ____ I avoid buying food in containers that leak, bulge, or are severely dented.

____ ____ I use separate cutting boards for meat and for foods that will be eaten raw.

____ ____ I thoroughly clean all equipment (cutting boards, counters, utensils) before and after use.

____ ____ I rinse and scrub fresh fruits and vegetables carefully to remove all dirt.

____ ____ I cook all foods thoroughly, especially beef, poultry, fish, pork, and eggs.

____ ____ I verify that hamburgers are cooked to 160°F (71°C) with a food thermometer.

____ ____ I store foods below 40°F (5°C).

____ ____ I do not leave cooked or refrigerated foods at room temperature for more than 2 hours.

____ ____ I thaw foods in the refrigerator or microwave.

____ ____ I use only pasteurized milk and juice.

____ ____ I avoid coughing or sneezing over foods, even when I'm healthy.

____ ____ I cover any cuts on my hands when handling food.

To Keep Your Immune System Healthy

____ ____ I eat a balanced diet, following the guidelines presented in the Dietary Guidelines for Americans.

____ ____ I maintain a healthy weight.

____ ____ I get enough sleep, 6–8 hours per night.

____ ____ I exercise regularly.

____ ____ I don't smoke, and I drink alcohol only in moderation.

____ ____ I wash my hands frequently.

____ ____ I have effective ways of coping with stress.

____ ____ I get all recommended immunizations and booster shots.

____ ____ *For people with heart valve disorders that place them at increased risk of infection:* I check with my health care provider about antibiotic use before dental or surgical procedures and before body piercing.

False answers indicate areas where you could change your behavior to help avoid infectious diseases. Consider creating a behavior change strategy for any statement you checked as false.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 99

Personal Infectious Disease Record

Place a check next to any of the following infectious diseases you have had. Where appropriate, list your age at the time of the infection and any special circumstances surrounding the time of the infection (e.g., your entire first grade class got the chicken pox; you got mononucleosis at a time of high stress) in the box provided. Circle any disease for which you have been vaccinated.

____ Athlete's foot	____ Lyme disease	____ Scarlet fever
____ Chicken pox	____ Malaria	____ Shingles
____ Chlamydia	____ Measles	____ Strep throat
____ Cold sores (HSV)	____ Meningitis	____ Syphilis
____ Diphtheria	____ Mononucleosis	____ Tetanus
____ Encephalitis	____ Mumps	____ Toxic shock syndrome
____ Genital herpes (HSV)	____ Whooping cough (pertussis)	____ Trichomoniasis
____ Genital warts (HPV)	____ Pinworm	____ Tuberculosis
____ Giardiasis	____ Pneumonia	____ Ulcer (*H. pylori*)
____ Gonorrhea	____ Poliomyelitis	____ Urinary tract infection
____ Hepatitis A	____ Pubic lice	____ Warts (site: _____)
____ Hepatitis B	____ Rabies	____ Yeast infection
____ Hepatitis C	____ Rheumatic fever	____ Other: _____
____ HIV infection	____ Ringworm	____ Other: _____
____ Influenza	____ Rubella (German measles)	____ Other: _____
____ Jock itch	____ Scabies	____ Other: _____

Disease	Age	Circumstances

(over)

INTERNET ACTIVITY

Choose one of the emerging infectious diseases described in the chapter or one you've heard about recently in the news. Use the sites below or perform a search to learn more about the disease. What causes the disease, and what are its effects? How is it transmitted? Where is it most common? What are some of the reasons for its emergence and/or spread? What can public health officials and individuals do to reduce the spread of the disease?

CDC National Center for Preparedness, Detection, and Control of Infectious Diseases: http://www.cdc.gov/ncpdcid
National Institute of Allergy and Infectious Diseases: http://www.niaid.nih.gov
World Health Organization: http://www.who.int/health_topics/en

Disease: _____

Site(s) visited (URL): _____

Information obtained:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 100

Allergy Record

Allergic disorders are very common among people of all ages. Put a check next to any of the following allergic disorders that you have experienced:

_____ Allergic rhinitis (persistent nasal congestion, runny nose, and/or postnasal drip)
_____ Atopic dermatitis (chronic or recurrent inflammation of the skin)
_____ Allergic conjunctivitis (red, itchy, watery eyes)
_____ Asthma
_____ Sinusitis (chronic sinus infection characterized by persistent cold symptoms, often including facial pain)
_____ Contact dermatitis (rash resulting from contact with an allergen)
_____ Food allergy
_____ Insect sting allergy
_____ Drug allergy

Next, create a record of your allergy triggers. Put a check next to any substance to which you have had an allergic reaction; if appropriate, list the specific type of substance you are allergic to (cats, spider bites, nuts, and so on). Describe the type of reaction you had:

✔	**Allergen**	**Specific Type(s)**	**Reaction(s)**
	Poison ivy or oak		
	Animals		
	Feathers		
	Insect bites or stings		
	Molds		
	Dust mites		
	Ragweed		
	Pollen		
	Foods		
	Other:		

(over)

Describe any allergy tests you've undergone and any treatments you received for allergies or asthma:

INTERNET ACTIVITY

Many people suffer from seasonal allergies, in which the severity of symptoms varies with the concentration of environmental allergens such as pollen. Current pollen counts and yearly pollen patterns are available from the Web site of the American Academy of Allergy, Asthma, and Immunology's National Allergy Bureau (http://www.aaaai.org/nab). Visit the site and locate the pollen information for the city closest to you. Check both today's pollen count and the record over time for the area. Which types of pollen are at the highest concentrations in which months? If you have allergies, can you see a relationship between your pattern of symptoms and the seasonal pattern of pollen concentrations in your area?

City: _____

Current pollen counts: _____

_____

_____

_____

Seasonal pattern (describe):

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 101

Facts About Sexually Transmitted Diseases

Familiarize yourself with different types of sexually transmitted diseases by completing the chart below:

	Early symptoms	Potential long-term effects	Diagnosis and treatment
HIV infection			
Chlamydia			
Gonorrhea			
Pelvic inflammatory disease			
Genital warts (HPV infection)			

(over)

	Early symptoms	Potential long-term effects	Diagnosis and treatment
Genital herpes			
Hepatitis B			
Syphilis			

INTERNET ACTIVITY

Visit several of the sites listed in the For More Information section of Chapter 18 in your text (Chapter 13 in the brief version)—or do a Web search—to complete one of the following activities.

1. Find information on STD prevention and safer sex. Look for strategies for talking with a sex partner, saying no to sex or drugs, or using a condom correctly.
2. Find information about a recent development or advance in HIV incidence, treatment, prevention, or testing. Look for a site with news posted within the past month.

Site visited (URL): _____

Information available from site:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 102

Do Your Attitudes and Behaviors Put You at Risk for STDs?

Part I. Risk Assessment

All sexually transmitted diseases are preventable. You have control over the behaviors and attitudes that place you at risk for contracting STDs and for increasing their negative effects on your health. To identify your risk factors for STDs, read the following list of statements and identify whether they're true or false for you.

Note: The statements in this assessment assume current sexual activity. If you have never been sexually active, you are not now at risk for STDs. Respond to the statements in the quiz based on how you realistically believe you would act. If you are currently in a mutually monogamous relationship with an uninfected partner or are not currently sexually active (but have been in the past), you are at low risk for STDs at this time. Respond to the statements in the quiz according to your attitudes and past behaviors.

True	False		
_____	_____	1.	I have only one sex partner.
_____	_____	2.	I always use a latex condom for each act of intercourse, even if I am fairly certain my partner has no infections.
_____	_____	3.	I do not use oil-based lubricants or other oil-based products with condoms.
_____	_____	4.	I discuss STDs and prevention with new partners before having sex.
_____	_____	5.	I do not use alcohol or another mood-altering drug in sexual situations.
_____	_____	6.	I would tell my partner if I thought I had been exposed to an STD.
_____	_____	7.	I am familiar with the signs and symptoms of STDs.
_____	_____	8.	I regularly perform genital self-examination to check for signs and symptoms of STDs.
_____	_____	9.	When I notice any sign or symptom of any STD, I consult my physician immediately.
_____	_____	10.	I obtain screening for HIV and other STDs regularly. In addition (if female), I obtain yearly pelvic exams and Pap tests.
_____	_____	11.	When diagnosed with an STD, I inform all recent partners.
_____	_____	12.	When I have a sign or symptom of an STD that goes away on its own, I still consult my physician.
_____	_____	13.	I do not use drugs prescribed for friends or partners or left over from other illnesses to treat STDs.
_____	_____	14.	I do not share syringes or needles to inject drugs.

False answers indicate attitudes and behaviors that may put you at risk for contracting STDs or for suffering serious medical consequences from them. For more on your risk factors for STDs, take the online assessment available at http://www.thebody.com/surveys/sexsurvey.html.

(over)

Part II. Communication

1. List three ways to bring up the subject of STDs with a new partner. How would you ask whether he or she has been exposed to any STDs or engaged in any risky behaviors? (Remember that because many STDs can be asymptomatic, it is important to know about past behaviors even if no STD was diagnosed.)

   a. _____

   _____

   b. _____

   _____

   c. _____

   _____

2. List three ways to bring up the subject of condom use with your partner. How might you convince someone who does not want to use a condom?

   a. _____

   _____

   b. _____

   _____

   c. _____

   _____

3. If you had an STD in the past that you might possibly still pass on (e.g., herpes), how would you tell your partner(s)?

   _____

   _____

   _____

4. If you were diagnosed with an STD that you believe was given to you by your current partner, how would you begin a discussion of STDs with him or her?

   _____

   _____

   _____

Talking about STDs may be a bit awkward, but the temporary embarrassment of asking intimate questions is a small price to pay to avoid contracting or spreading disease.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 103

Facts About Environmental Health

Review your knowledge of important issues in environmental health by answering the questions below. Refer to your textbook if necessary.

1. List two current problems regarding clean water and a possible solution for each:

   a. _____

   _____

   b. _____

   _____

2. What are the major components of household trash? What are some of the problems with trash disposal?

   _____

   _____

   _____

   _____

3. List three factors that contribute to population growth and three factors that may limit it:

   a. _____ d. _____

   b. _____ e. _____

   c. _____ f. _____

4. What is a temperature inversion, and why is it dangerous?

   _____

   _____

   _____

   _____

5. What is the greenhouse effect?

   _____

   _____

   _____

   _____

6. What is the ozone layer, and why is it important to human health?

   _____

   _____

   _____

   _____

(over)

How and where does thinning of the ozone layer occur?

7. How fast is the world's population growing?

8. List and describe two current chemical pollution problems. What are the effects of each chemical? How do people come in contact with them?

   a. _____

   b. _____

9. What negative effects can occur when an individual is exposed to loud and persistent noise?

10. What is biodiversity, and why is it important?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 104

Environmental Health Checklist

The following list of statements relates to your impact on the environment. Put a check next to the statements that are true for you.

Conserving Energy and Improving the Air

____ I ride my bike, walk, use public transportation, or carpool in a fuel-efficient vehicle whenever possible.

____ I keep my car tuned up and well maintained.

____ My vehicle is fuel efficient (city: ____ MPG; highway: ____ MPG).

____ My car tires are inflated at the proper pressure.

____ I avoid quick starts and drive within the speed limit.

____ I don't use my car's air conditioner when opening the window would suffice.

____ My residence is well insulated.

____ Where possible, I use compact fluorescent bulbs instead of incandescent bulbs.

____ I turn off lights and appliances when they are not in use.

____ I avoid turning on heat or air conditioning whenever possible.

____ I run the washing machine, dryer, and dishwasher only when they have full loads.

____ I dry my hair with a towel rather than a hair dryer.

____ I keep my car's air conditioner in good working order and have it serviced by a service station that recycles CFCs.

____ I have an energy-efficient refrigerator, which I keep in good working order.

Reducing Garbage

____ When shopping, I choose products with the least amount of packaging.

____ I choose recycled and recyclable products and those sold in bulk.

____ I avoid products packaged in plastic and unrecycled aluminum.

____ I store food in glass jars and reusable plastic containers rather than using plastic wrap.

____ I take my own bag along when I go shopping.

____ Whenever possible, I use long-lasting or reusable products (such as refillable pens and rechargeable batteries).

____ I use a ceramic mug and metal spoon for coffee and tea rather than disposable cups and stirrers.

____ I recycle newpapers, glass, cans, paper, and other materials.

____ I have a compost pile or bin for my organic garbage or I take my organic garbage to a community composting center.

Reducing Chemical Pollution and Toxic Wastes

____ When shopping, I read labels and try to buy the least toxic products available.

____ I don't pour toxic materials (bleach, motor oil, etc.) down the sink.

(over)

____ If I am unsure of the proper way to dispose of something, I contact my local health department or environmental health office.

____ Whenever possible, I buy organic produce or produce that is in season and has been grown locally.

Saving Water

____ I take showers instead of baths.

____ I take short showers and switch off the water when I'm not actively using it.

____ I do not run the water while brushing my teeth, shaving, or hand-washing clothes or dishes.

____ My sinks have aerators installed in them.

____ My shower has a low-flow showerhead.

____ I have a water-saving toilet, or I have a water-displacement device in my toilet.

____ I fix any faucets that leak.

Preserving Wildlife and the Natural Environment

____ I snip or rip plastic six-pack rings before discarding them.

____ I don't buy products made from endangered species.

____ When hiking or camping, I never leave anything behind.

Statements that you have not checked can help you identify behaviors that you can change to improve environmental health. Consider planning a behavior change activity to alter one or more of your behaviors. To change some of the items listed, you may need the cooperation of your family and/or roommate(s). If there are environmental issues that are important to you, you can go beyond individual action by informing others, joining and volunteering your time to organizations working on environmental problems, and contacting your elected representatives.

INTERNET ACTIVITY

Writing letters to elected officials is one way you can become more involved in promoting environmental health. Choose one of your representatives—local, state, or United States Congress—and locate her or his e-mail address. To locate contact information, visit one of the following sites or do a Web search: U.S. Senate (http://www.senate.gov); U.S. House of Representatives (http://www.house.gov/writerep). Fill in the e-mail address of your representative, and briefly describe how you located it:

Name: _____

Position: _____

E-mail address: _____

How located:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 105

Recycling and Shopping Planner

Part I. Recyclables Reminder

Research the recycling facilities in your area. For each type of recyclable, fill in where it can be recycled and what preparation is required (for example, removing labels or tying bundles).

ALUMINUM AND STEEL CANS

	Type	*Can be recycled at (location):*
____	Aluminum cans	_____
	____ Foil OK?	
	____ Pie plates, frozen food trays, etc. OK?	
____	Steel cans	_____

Preparation: _____

GLASS

	Type	*Can be recycled at (location):*
____	Clear glass	_____
____	Green glass	_____
____	Amber glass	_____

Preparation: _____

PAPER

	Type	*Can be recycled at (location):*
____	Newspaper	_____
____	Corrugated cardboard	_____
	____ Brown paper bags OK?	
____	Office paper	_____
	____ Laser-printed paper OK?	
____	Mixed papers	_____
	____ Acceptable papers are:	_____
____	Glossy paper	_____
	____ Glued bindings OK?	

Preparation: _____

PLASTIC

	Type	*Can be recycled at (location):*
____	1 PET or PETE	_____
____	2 HDPE	_____
____	Others?	_____

(over)

Preparation: _____

OTHER

	Type	*Can be recycled at (location):*
____	Batteries (home)	_____
____	Batteries (car)	_____
____	Motor oil	_____
____	Paint	_____
____	_____	_____

Preparation: _____

Part II. Critical Shopping for Environmental Health

You can promote environmental health by purchasing sustainable products whenever possible. A product is sustainable if it is made, used, and disposed of in such a way that it could continue to be made, used, and disposed of again and again. To begin building your environmental shopping skills, choose a product and ask yourself the following questions about it.

Product: _____

1. Do I really need this product? Why? (Every product you *don't* buy saves resources and eliminates waste.)

2. Is the product safe to use? (Choose nontoxic alternatives whenever possible.)

3. Is the product practical, durable, well made, of good quality, with a timeless design? Will I be able to keep it for a long time before replacing it? (Products that last are better for the environment.)

4. Is the product made from renewable or recycled materials?

5. How will I dispose of the product, and what environmental impact will that disposal have?

6. What kind of package does the product have?

7. How far has the product been shipped to reach the retail outlet? (Products produced locally use fewer resources and produce less pollution during transport.)

8. Is the product a good value for the money? Is the environmental health benefit the product provides worth the extra cost?

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 106

Choosing a Primary Care Physician

To help evaluate your current physician or choose a new one, fill in the requested information and complete the checklist.

General Information

Physician name: _____ Training/certification: _____

Office location: _____ Hospital privileges: _____

_____ _____

Office phone: _____ Office hours: _____

Does the physician take my current insurance? _____ Is she or he accepting new patients? _____

Is advice available by phone? If so, at what number and at what times? _____

Is advice available by e-mail? If so, at what e-mail address? _____

Who covers for the physician when she or he is unavailable? _____

What should I do if I need care urgently? _____

Yes	No	
____	____	The office appears to be run efficiently.
____	____	The office atmosphere is friendly and reassuring.
____	____	The office staff is helpful when I call for an appointment or arrive for a visit.
____	____	The wait for a routine appointment is acceptable (typical time: _____).
____	____	Phone calls are returned in a timely manner.
____	____	Privacy is provided when I am asked personal questions.
____	____	The office sends reminders about preventive tests such as Pap tests.
____	____	The physician has expertise or experience treating conditions of concern to me (list: _____ _____).
____	____	The physician seems thorough when taking my medical history.
____	____	The physician gives me enough time to completely describe my problem or concern.
____	____	The physician answers all my questions.
____	____	The physician treats me with respect.
____	____	The physician explains things clearly: I understand my diagnosis, the reason for any tests or treatments, how to use prescribed medications, and so on.
____	____	The physician discusses preventive care and lifestyle changes, such as smoking cessation and regular exercise.
____	____	The physician supports my decision to seek a second opinion when I feel it's necessary.
____	____	The physician refers me to a specialist when indicated.
____	____	Overall, the physician makes me feel comfortable with and confident of the services she or he is providing.

"No" answers may indicate areas where your relationship with a physician or the running of the office may be less than ideal. Discuss any areas of concern with your physician. If things do not improve, consider changing physicians. Remember, your physician works for you.

(over)

INTERNET ACTIVITY

Information about many U.S. physicians and hospitals is available online. Choose a local physician or hospital, and see what information you can find from the following sites. Alternatively, search for a physician with a particular type of specialty practicing in your area.

American Medical Association (Doctor Finder): http://www.ama-assn.org
American Board of Medical Specialties: http://www.abms.org
Health Grades: http://www.healthgrades.com
Joint Commission: http://www.jointcommission.org
Public Citizen: http://www.citizen.org/hrg

Site(s) visited (URL): _____

Name of physician or hospital: _____

Information obtained:

Next, search for a local clinic, hospital, or physician's office. Do any of the medical facilities in your area sponsor their own Web site? If so, describe the information available at the site.

Clinic, hospital, or medical office: _____

Site visited (URL): _____

Information available:

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 107

Complementary and Alternative Medicine (CAM)

One of the most controversial and fastest growing areas of health care is the use of complementary and alternative therapies such as acupuncture, massage therapy, and dietary supplements. Because there is less information about CAM therapies and less regulation of the associated products and providers, it is important for consumers who choose to use CAM to take an active role in their health care, to use their critical thinking skills, and to be cautious. In addition, the lack of information means that any treatment decisions are likely to be a matter of individual judgment. However, there are steps consumers can take to help increase their safety.

Working with Your Physician

The NIH National Center for Complementary and Alternative Medicine (NCCAM) cautions consumers not to seek CAM therapies without first consulting a licensed health care provider. Check off the following steps as you complete them.

____ Visit a physician for an evaluation and diagnosis of your symptoms.

____ Discuss and try conventional treatments that have been shown to be beneficial for your condition.

____ Inform your physician of any CAM therapies you are trying or thinking of trying. This is critically important because a CAM therapy may interact dangerously with a conventional treatment that you are receiving.

____ Ask your physician if she or he has any concerns about any CAM treatment you are considering, particularly in the following areas:

- ____ *Safety*. Is there something unsafe about the treatment in general or specifically for you? Is there anything she or he is aware of that could increase the safety of the therapy?
- ____ *Effectiveness*. Is she or he aware of any research about the use of the therapy for your condition?
- ____ *Timing*. Is the immediate use of a conventional treatment indicated?
- ____ *Cost*. Does she or he think the therapy is likely to be very expensive, especially in light of the potential benefit?

____ If you plan to pursue a CAM therapy against your physician's advice, tell her or him.

____ If appropriate, schedule a follow-up visit with your physician to assess your condition and your progress after a certain amount of time using a CAM therapy.

____ Keep a symptom diary to more accurately track your symptoms and gauge your progress. (Symptoms such as pain and fatigue are very difficult to recall with accuracy, so an ongoing symptom diary is an important tool.)

Investigating CAM Therapies and Practitioners

____ To the best of your ability, determine whether any research has been conducted on the CAM therapy you are considering. What studies have been done to test its safety? Its effectiveness for your condition? Use the Internet to search for information. One database, called CAM on PubMed, has been developed by the National Library of Medicine and the NCCAM; it provides citations and abstracts of peer-reviewed scientific studies on CAM therapies. If you don't have access to the Internet, contact the NCCAM Clearinghouse (1-888-644-6226), visit your local library, or ask your physician about resources.

(over)

____ If possible, talk to people with the same condition you have who have received the same treatment. (Remember, however, that patient testimonials should not be used as the sole criterion for choosing a therapy or assessing its safety and efficacy. Controlled scientific trials usually provide the best information and should be consulted whenever possible. The absence of documented dangers is not the same thing as proof of safety.)

____ Review the CAM practitioner's credentials. Ask about education, training, licensing, and certification. Examine the condition of the office or clinic. Does it seem well organized and well run?

____ If appropriate, check with the appropriate state or local regulatory agency or consumer affairs department to determine if any complaints have been lodged against the practitioner.

____ Ask the practitioner why she or he thinks the treatment will be beneficial for your condition. Ask her or him to fully describe what the treatment consists of and any potential problems.

____ Fully describe any conventional treatments you are currently undergoing.

____ Find out about the expected duration of treatment.

____ Find out about the expected cost of the treatment. Does it seem reasonable? Will your health insurance pay some or all of the costs?

If anything a CAM practitioner says or recommends directly conflicts with advice from your physician, you should discuss it with your physician before making any major changes in any current treatment regimen or in your lifestyle. Additional consumer-oriented advice about CAM therapies can be found in your text in the sections on dietary supplements, cancer quackery, and general health fraud.

INTERNET ACTIVITY

Choose one CAM therapy to investigate. Use the resources listed below or do a search to locate at least one research study on the therapy you've chosen to investigate. Once you find a study, look closely at it. How big was the study? Who were the participants? What was the purpose of the study? What did the study find? Can you determine if it had any of the characteristics of a well-designed study described in Chapter 20 (Chapter 15 in the brief version): placebo-controlled, randomized, and double-blind? Was it published in a peer-reviewed medical journal?

National Center for Complementary and Alternative Medicine: http://nccam.nih.gov
National Library of Medicine: PubMed: http://www.pubmed.gov
National Library of Medicine and NCCAM: CAM on PubMed: http://www.nccam.nih.gov/camonpubmed
NIH Office of Dietary Supplements: http://dietary-supplements.info.nih.gov

Site visited (URL): _____

Therapy: _____

Citation of study: _____

_____

Description of study:

Finally, search the Web site of the FDA (http://www.fda.gov) or the Federal Trade Commission (FTC; http://www.ftc.gov) for the therapy you investigated to see if there are any consumer warnings about particular treatments, products, or devices. Describe what you find:

SOURCES: National Center for Complementary and Alternative Medicine. 2006. *Are You Considering Using CAM?* (http://nccam.nih.gov/health/decisions; retrieved December 1, 2008); Considering alternative medicine? 1998. *Tufts University Health and Nutrition Letter,* November; Eisenberg, D. M. 1997. Advising patients who seek alternative medical therapies. *Annals of Internal Medicine* 127:61–69.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 108

Your Personal Health Profile

Complete as much as possible of this personal health profile and keep it with Wellness Worksheets 99 and 100 (Personal Infectious Disease Record and Allergy Record) so that you have a complete record of your health status. Keep your profile up to date.

General Information

Age: _____

Height: _____

Weight: _____

Are you currently trying to _____ gain or _____ lose weight? (check if appropriate)

Blood pressure: _____ / _____

Blood lipid levels:

Total cholesterol: _____

HDL: _____

LDL: _____

Triglycerides: _____

Blood glucose level: _____

Medical Conditions

Check any of the following that apply to you and add other conditions that might affect your health and well-being:

____ heart disease
____ lung disease
____ diabetes
____ allergies
____ asthma
____ back pain
____ arthritis
____ other injury or joint problem
____ substance abuse problem
____ depression, anxiety, or another psychological disorder
____ eating disorder
____ other: _____
____ other: _____

List any conditions or diseases that are common in your family and/or ethnic group (see Wellness Worksheets 8 and 45):

_____ _____

_____ _____

_____ _____

Medications/Treatments

List any medications or supplements you are taking or any medical treatments you are undergoing. Include the name of the substance or treatment and its purpose. Include both prescription and over-the-counter drugs and any vitamin, mineral, or other dietary supplement you are taking.

Medication/treatment:	Condition/purpose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(over)

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Insel/Roth, *Connect Core Concepts in Health,* Brief Twelfth Edition © 2012 The McGraw-Hill Companies, Inc. Chapter 15

Screening Tests and Vaccinations

To ensure that you are getting the most out of your medical care, keep a record of your screening tests and vaccinations.

Screening test/immunization	Date last performed
Blood pressure check	
Cholesterol measurement	
Vision test	
Dental exam	
STD screening, including HIV test	
Pelvic exam and Pap test (women only)	
Clinical breast exam (women only)	
Tetanus/diphtheria/pertussis vaccination	
Influenza vaccination	
Varicella vaccination	
Zoster vaccination	
Measles, mumps, rubella (MMR) vaccination	
Pneumococcal (polysaccharide) vaccination	
Hepatitis A vaccination	
Hepatitis B vaccination	
HPV vaccination	
Meningococcal disease vaccination	
other:	
other:	

Health Care Providers

Primary care physician: name: _____ phone: _____

Specialist physician: name: _____ phone: _____

Condition treated: _____

Other health care provider: name: _____ phone: _____

Condition treated: _____

Pharmacy: name: _____ phone: _____

Dentist: name: _____ phone: _____

Optometrist/ophthalmologist: name: _____ phone: _____

Health insurance provider: name: _____ phone: _____

Policy number: _____

Dental insurance provider: name: _____ phone: _____

Policy number: _____

Vision care insurance provider: name: _____ phone: _____

Policy number: _____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 109

Safe Use and Storage of Medications

Medication Checkup

To help determine if you know all you need to in order to use your medications safely, complete as much of the following information as possible for the most recent over-the-counter or prescription medication that you have used. Consult the label or package inserts if needed.

Name/brand:	
Use (condition or symptom):	
Directions for use: dose (amount), frequency, timing (with meals?), in cases of a missed dose:	
Total period of time for use:	
How soon to expect improvement, and action to take if no improvement occurs:	
Warnings/contraindications for use:	
Possible side effects and what to do:	
Serious reactions to watch for and report:	
Activities or substances to avoid:	
Instructions in case of overdose:	
Storage and other information:	
Number of refills:	
Expiration date:	
Other medications or supplements in use:	
Safety of use of this combination checked with physician or pharmacist?	

Note: For both OTC and prescription medications, it's important to check with a physician or pharmacist about the safety of using any medications in combination with each other or with dietary supplements.

Your Home Medical Care Kit

Most medications should be stored in a cool, dark, and dry place, preferably in a locked container and out of a child's reach (such as the top of a linen closet). If exposed to the heat and humidity of a bathroom, many drugs deteriorate rapidly. Use your bathroom medicine cabinet for supplies that aren't affected by heat and humidity. Evaluate your home medical care kit using the following checklist. Before checking off any item, however, make sure that its expiration date hasn't passed. Throw out expired items and consider purchasing any supplies that you don't check off. Add any items that are appropriate for you: for example, if you sometimes have exercise-related injuries, you might want to keep an ice pack, heating pad, and elastic bandage on hand; if you have allergies, you might add a decongestant to the list.

(over)

Closet

____ Analgesic (relieves pain)
____ Antacid (relieves upset stomach)
____ Antibiotic ointment (reduces risk of infection)
____ Antihistamine (relieves allergy symptoms)
____ Antiseptic (helps stop infection)
____ Fever reducer (adult and child)
____ Hydrocortisone (relieves itching and
____ inflammation)
____ Other: _____
____ Other: _____
____ Other: _____
____ Other: _____

Medicine cabinet

____ Adhesive bandages
____ Adhesive tape
____ Alcohol wipes
____ Calibrated measuring spoon
____ Disinfectant
____ Gauze pads
____ Thermometer
____ Tweezers
____ Other: _____
____ Other: _____
____ Other: _____
____ Other: _____

INTERNET ACTIVITY

Choose a prescription or over-the-counter drug to research. Use one or more of the following sites or do a search to find out more information about the drug.

HealthSquare Drug Information Center: http://www.healthsquare.com/drugmain.htm
Mayo Health (click on Drugs and Supplements): http://www.mayoclinic.com
MedicineNet (click on Medications): http://www.medicinenet.com
MedlinePlus Drug Information: http://www.nlm.nih.gov/medlineplus/druginformation.html

Drug/medication:

Site visited (URL):

Uses for medication:

How taken (dosage/administration):

Precautions:

Side effects and drug interactions:

Other warnings and information:

Finally, compare what you've learned to the list of key questions provided by the U.S. Pharmacopoeia (http://www.usp.org/pdf/EN/patientSafety/justAskDozenQs.pdf). What additional information would you need to understand to safely use this medication?

SOURCE: List of items for medical care kit from Lewis, C. 2000. Your medicine cabinet needs an annual checkup, too. *FDA Consumer,* March/April.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 110

Self-Treatment: Visualization and Expressive Writing

There are many nondrug self-help options for mild symptoms or as an adjunct to medical treatment for various chronic conditions. Two that you might consider trying are visualization and expressive writing.

Imagine Yourself Well

To practice visualization, set aside 10–30 minutes of quiet, undisturbed time. Wear loose, comfortable clothing. Sit in a comfortable chair or lie on a pad or carpeted floor with a pillow under your head. Do whatever you can to enhance your comfort. Dim the lights and put on soft music if you like. Practice the technique at least three or four times a week; it will likely take several weeks of practice before you really start to notice benefits.

You can engage in a general visualization exercise for relaxation by imagining yourself in a special place that you enjoy and where you feel safe, such as a beach, a beautiful garden, or a mountain trail. Although imagery most often uses your sense of sight, you can also include the experiences of your mind's other senses—smells, tastes, sounds, and other sensations such as a breeze on your face or sand beneath your feet—to make the experience more vivid and powerful.

You can also use imagery to focus on alleviating specific symptoms or illnesses. Use any image that is strong and vivid for you (this often involves using all your senses to create the image), and one that is meaningful to you. The image does not have to be physiologically accurate for it to work. Just use your imagination and trust yourself. The following are examples of images that some people have found useful:

- **Tension and stress:** a tight twisted rope slowly untwists; wax softens and melts; tension swirls out of your body and down the drain
- **Healing of cuts and injuries:** plaster covers over a crack in a wall; cells and fibers stick together with superglue; a shoe is laced up tight; jigsaw puzzle pieces come together
- **Pain:** all of the pain is placed in a large, strong metal box, closed, sealed tightly, and locked with a huge, strong padlock; you grasp the TV remote control and slowly turn down the pain volume until you can barely hear it, and then it disappears entirely; the pain is washed away by a cool, calm river flowing through your entire body
- **Infections:** white blood cells with flashing red sirens arrest and imprison harmful germs; an army equipped with powerful antibiotic missiles attacks enemy germs; a hot flame chases germs out of your entire body
- **Allergies, asthma, and lung diseases:** the tiny elastic rubber bands that constrict your airways pop open; a vacuum cleaner gently sucks the mucus from your airways; waves calmly rise and fall on the ocean surface; hyperalert immune cells in the fire station are reassured that the allergens have triggered a false alarm, and they can go back to playing their game of cards; the civil war ends with the warring sides agreeing not to attack their fellow citizens
- **Depression:** your troubles and feelings of sadness are attached to big colorful helium balloons and are floating off into a clear blue sky; a strong, warm sun breaks through dark clouds; you feel a sense of detachment and lightness, enabling you to float easily through your day
- **Diabetes:** small insulin keys unlock doors to hungry cells and allow nourishing blood sugar in; an alarm goes off and a sleeping pancreas awakens to the smell of freshly brewed coffee
- **Behavior change:** if you are somewhat shy, imagine a vivid, detailed picture of yourself walking up to people and chatting with them confidently; if you want to be more physically active, see yourself walking in the park, riding a bike, taking a dance class, or joining a sports team

(over)

Symptom/condition targeted: _____

Imagery used (one of the previous examples or something you develop for yourself): _____

_____

_____

How did you feel before and after your session of visualization? _____

_____

After several weeks of practice, did you notice any effects? _____

_____

Expressive Journal Writing

Writing down feelings and thoughts about stressful life events has been shown to help people with chronic conditions improve their health. Use the space below to get started. Set aside a special time and write in a place where you won't be interrupted or distracted. Choose a life event that you found particularly stressful, and write about your very deepest thoughts and feelings. You may find the writing exercise to be distressing in the short term—sadness or depression are common when dealing with feelings about a stressful event—but most people report relief and contentment soon after writing for several days. (See the specific suggestions in Wellness Worksheet 18.)

SOURCE: Visualization instructions and examples from Sobel, D. S., and R. Ornstein. 1996. *The Healthy Mind, Healthy Body Handbook*. Los Altos, Calif.: DRx. Reprinted by permission.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 111

Communicating with Your Physician

The time constraints of a typical medical visit make it essential that you prepare for your visit to a health care professional and use your time to maximum advantage. To help get more out of your next medical visit, fill in the following information and use the checklist.

Before the Visit

Prepare a list of concerns, questions, and observations. Bring the list with you to the appointment and refer to it as needed.

Primary reasons for visiting physician (choose a reasonable number given the length of the scheduled appointment):

_____

_____

_____

Notes about symptoms (when they started, how long they last, exactly where they are located, what makes them worse and what makes them better):

_____

_____

_____

Special concerns about your symptoms (for example, fear of having a serious disorder or of being contagious):

_____

_____

What treatments you have already tried:

_____

_____

What you think might be causing the problem (for example, a recent camping trip or sexual encounter):

_____

_____

Medications and supplements you are currently taking:

_____

_____

Relevant medical history (allergies, pregnancy, past illnesses):

_____

_____

What you most want to get out of your visit:

_____

_____

(over)

During the Visit

The following strategies can help you get more out of a medical visit; check off those you use during your visit.

____ Present key concerns at the very beginning of the visit.

____ State concerns specifically and concisely, using the notes prepared beforehand.

____ Be open and honest about health concerns, symptoms, and physician recommendations.

____ Ask questions.

____ Participate in the decision-making process about a treatment plan.

At the End of the Visit

Before you leave the appointment, you should be able to fill in the following information; if you can't, ask your physician for clarification or further information.

The diagnosis (the nature and cause of your symptoms):

_____

_____

_____

The prognosis (the expected duration, course, and outcome of the condition):

_____

_____

_____

The physician's treatment recommendations and instructions—what you are supposed to do:

_____

_____

_____

The follow-up plan (returning for a visit, phoning for test results, reporting any specific signs or symptoms, etc.):

_____

_____

_____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 112

Understanding Health and Medical Terminology

How well do you understand the terminology used by health care providers and public health officials? See how many of the following medical and health terms you can match with their correct definitions.

___ 1. Acute

___ 2. Adverse health effect

___ 3. Additive effect

___ 4. Analgesic

___ 5. Antagonistic effect

___ 6. Atrophy

___ 7. Benign

___ 8. Carcinogen

___ 9. Chronic

___ 10. Cyst

___ 11. Degenerative disorder

___ 12. Dermal

___ 13. Diagnosis

___ 14. Edema

___ 15. Hematoma

___ 16. Incidence

___ 17. Ingestion

___ 18. In vitro

___ 19. In vivo

___ 20. Ischemia

___ 21. Lesion

___ 22. Malignant

a. A bruise

b. A change in the DNA, genes, or chromosomes of living organisms.

c. A closed, fluid-filled, or semisolid sac embedded in tissue

d. A condition characterized by deterioration of body parts that worsens over time

e. A negative or problematic change in body function

f. A response to multiple substances in which one substance amplifies the effect of another; the combined effect of the substances acting together is greater than the sum of the effects of the substances acting by themselves

g. A response to multiple substances that is equal to the sum of the effects of all the substances added together

h. A response to multiple substances that is less than would be expected if the effects of the individual substances were added together

i. A sore

j. A statement made by a government agency informing the public that a potentially hazardous condition exists, along with guidelines for avoiding or preventing exposure

k. A substance that causes cancer

l. Abnormal accumulation of fluid in the cells, especially just under the skin or in an organ such as the heart

m. Affecting the whole body

n. Aftereffects of an illness

o. Any medical technique that does not involve puncturing or entering the body

p. An assessment of the future course or outcome of a disease

q. Cancerous; tending to become worse or invasive

r. Decreased supply of oxygenated blood to any part of the body

s. Diagnostic technique of feeling, with the hands, the firmness, texture, or location of various body parts

t. Disappearance of the signs and symptoms of a disease

(over)

___ 23. Morbidity

___ 24. Mortality

___ 25. Mutation

___ 26. Noninvasive

___ 27. Palpation

___ 28. Palpitation

___ 29. Prevalence

___ 30. Prognosis

___ 31. Pruritus

___ 32. Public health advisory

___ 33. Recurrence

___ 34. Remission

___ 35. Rhinitis

___ 36. Risk

___ 37. Sepsis

___ 38. Sequelae

___ 39. Synergistic effect

___ 40. Systemic

u. In an artificial environment outside a living organism or body

v. Infection or contamination

w. Inflammation of the nasal membranes, often caused by the common cold

x. Itching

y. Noncancerous; harmless

z. Occurring over a long time

aa. Occurring over a short time

bb. Pain reliever

cc. Pounding or racing of the heart

dd. Referring to the skin

ee. Relating to death

ff. Relating to illness or disease; state of being ill or diseased

gg. Shrinkage of muscle or tissue

hh. The act of swallowing something through eating, drinking, or mouthing objects

ii. The identification of a disease or condition, usually made by examining the patient's history, symptoms, appearance, and analysis of tests

jj. The number of cases of a disease in a certain population at a specific point in time

kk. The number of new cases of a disease in a certain population in a specific period of time

ll. The probability that something will cause injury or harm

mm. The return of a disease.

nn. Within a living organism or body

Answers: 1. aa; 2. e; 3. g; 4. bb; 5. h; 6. gg; 7. y; 8. k; 9. z; 10. c; 11. d; 12. dd; 13. ii; 14. l; 15. a; 16. kk; 17. hh; 18. u; 19. nn; 20. r; 21. i; 22. q; 23. ff; 24. ee; 25. b; 26. o; 27. s; 28. cc; 29. jj; 30. p; 31. x; 32. j; 33. mm; 34. t; 35. w; 36. ll; 37. v; 38. n; 39. f; 40. m

Scoring:

30–40 correct answers: You have an excellent grasp of commonly used health and medical terminology.

20–29 correct answers: Your knowledge of terminology is good.

10–19 correct answers: Your knowledge of terminology is fair.

Fewer than 10 correct answers: You may be at a disadvantage in communicating with your health care providers and understanding health messages.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 113

Choosing a Health Care Plan

The following questions are designed to help you evaluate different health care plans and choose the most appropriate one for you.

Quality and Accreditation

How is the plan rated for quality? (Possible sources of ratings include the Consumer Assessment of Healthcare Providers and Systems [CAHPS], the Healthcare Effectiveness Data and Information Set [HEDIS], or your state health insurance commissioner.)

_____

_____

_____

Is the plan accredited and, if so, by what organization(s)? (Many health plans choose to be reviewed and accredited by the National Committee for Quality Assurance [NCQA], the Joint Commission, or the American Accreditation HealthCare Commission/URAC.)

_____

_____

Choice of Physician/Facilities

Are restrictions placed on your choice of physician? _____

Is your current physician covered by the plan? _____

Is the hospital you prefer, or where a particular physician has privileges, covered by the plan? _____

_____

Are there any restrictions on your choice of clinic, hospital, or emergency room? _____

_____

If you must choose a new physician or facility, are services available at convenient times and locations? _____

_____

Services

What services does the policy cover? Check those that are covered; circle those you are most likely to need.

____ Physician visits
____ Preventive care
____ Prescription medications
____ X rays and lab services
____ Out-of-town care
____ Emergency room care
____ Allergy testing and treatment
____ Mental health services
____ Substance abuse treatment
____ Prenatal care and routine deliveries
____ Well baby care
____ Ambulance service
____ Hospitalization
____ Second opinions

(over)

____ Contraceptives
____ Vision care and glasses/contact lenses
____ Dental care
____ Physical therapy
____ Complementary and alternative therapies (e.g., chiropractic)
____ Surgical costs, including anesthesia
____ Transfusions
____ Skilled home nursing care
____ Other: _____
____ Other: _____

Restrictions/Exclusions

Are there exclusions for any preexisting conditions? If so, list any that would affect you: _____

_____

_____

How long must you be free of symptoms before these would be covered? _____

Is preauthorization required for any service? _____ Which services? _____

_____

Does the policy exclude particular conditions? If so, list any exclusions that may affect you: _____

_____

_____

Costs

Monthly or yearly premium: _____

Annual deductible: _____

Copayments: physician visit _____ urgent care _____ emergency room _____
prescriptions _____ hospital stay _____ other _____

Does the policy pay only the "usual" or "customary" fee for particular services? _____

Is there a maximum limit of coverage, either on a yearly basis or over the life of the policy? Are there limits on the coverage of any particular conditions? _____

_____

If you visit a physician outside the plan, what percentage of the cost is covered? _____

_____

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 114

Checklist for Preventing Unintentional Injuries

Put a check next to the answer that best describes your behavior, and fill in the requested information.

Yes No

Automobile/Truck Safety

_____ _____ I obey the speed limit at all times.

_____ _____ I follow the "3-second rule" to avoid following too closely: When the vehicle ahead passes a reference point, I count "one-thousand-one, one-thousand-two, one-thousand-three" (about 3 seconds). If I pass the reference point before I finish counting, I allow more space.

_____ _____ I slow down and allow more space between myself and the vehicle ahead when environmental conditions are not ideal (bad weather, poor road conditions, etc.).

_____ _____ I always wear a safety belt, even when the vehicle has air bags.

_____ _____ I always securely strap infants or toddlers into appropriate child safety or booster seats in the back seat of the car.

_____ _____ I never drink or use drugs and then drive.

_____ _____ I never get into a car if the driver has been drinking or using drugs.

_____ _____ I always signal when turning.

_____ _____ I avoid driving when drowsy.

_____ _____ I don't talk on the phone or text while driving.

_____ _____ I always come to a complete stop at a stop sign or flashing red light.

_____ _____ I take special care at intersections: I look left, right, and then left again.

_____ _____ I don't pass on two-lane roads unless I'm in a designated passing area (broken line) or I have a clear view of oncoming traffic.

_____ _____ When given the choice between an interstate road and a rural road, I would choose to drive on the interstate.

_____ _____ When I buy a car, safety is one of my primary considerations.

_____ _____ I keep my car in good working order and regularly check:

_____ Tires _____ Brakes _____ Steering

_____ Lights _____ Windshield wipers _____ Oil and fluid levels

Motorcycle/Scooter Safety

_____ _____ I always wear an approved helmet.

_____ _____ I always use eye protection (goggles, eye shields, or a windshield).

_____ _____ I wear long pants and a sturdy jacket to reduce injury in case of a fall.

_____ _____ I do everything possible to make myself more visible to other motorists.

_____ I wear light-colored clothing.

_____ I keep my headlight on at all times.

_____ I avoid changing lanes unless absolutely necessary.

_____ I avoid riding between lines of moving cars.

_____ _____ I have received proper training and adequate practice, and I have the skills to operate my motorcycle/scooter safely.

(over)

Yes **No**

Cycling Safety

_____ _____ I know and follow the rules of the road.

_____ _____ I always ride with the flow of traffic.

_____ _____ I know and use proper hand signals.

_____ _____ I always ride defensively; I never assume that drivers have seen me.

_____ _____ I take special care in turning or crossing at corners and intersections.

_____ _____ I stop at all traffic lights and stop signs.

_____ _____ I keep my bike well-maintained.

_____ _____ I wear light-colored, reflective clothing that maximizes my visibility.

_____ _____ I always wear safety equipment:

_____ Helmet _____ Gloves

_____ Appropriate footwear _____ Reflective equipment at night

_____ Eye protection _____ Pants clips or bands

_____ _____ I use bike paths whenever possible.

Pedestrian Safety

_____ _____ I cross streets only in designated crosswalks.

_____ _____ I wait for a green light to cross the street.

_____ _____ I wear clothes that will make me more visible to drivers.

_____ _____ I never hitchhike.

Jogging Safety

_____ _____ I avoid busy roadways with poor visibility when possible.

_____ _____ I run against the flow of traffic.

_____ _____ I dress to be highly visible to drivers.

_____ _____ I jog during the day.

_____ _____ I don't listen to a radio, tape, or CD with headphones while jogging.

Swimming/Boating Safety

_____ _____ I do not attempt to swim distances that are beyond my physical capabilities.

_____ _____ I avoid swimming in dangerous or uncertain locations or situations.

_____ _____ I avoid swimming long in water that is colder than 70°F (21°C).

_____ _____ I do not use drugs or alcohol before I swim or while boating.

_____ _____ I always swim with at least one other person.

_____ _____ When boating, I wear an appropriate personal flotation device (PFD).

_____ _____ I know and follow safe boating rules.

_____ _____ I check water depth before diving.

(over)

Yes No

Sports Safety

_____ _____ I participate only in those sports in which I have sufficient skill to play safely.

_____ _____ I recognize and guard against any hazards commonly associated with the sports I choose.

_____ ____ I include appropriate exercises for conditioning, warming up, and cooling down.

_____ ____ I use proper safety equipment and appropriate facilities (e.g., helmets, eye protection, knee and elbow pads, etc.).

_____ _____ I know how to recognize and avoid heat-related illness.

For the sport you most commonly participate in, list three common hazards and three pieces of needed safety equipment:

1. _____ 1. _____
2. _____ 2. _____
3. _____ 3. _____

Hiking/Backpacking/Outdoor Activity Safety

_____ _____ I never hike or backpack alone.

_____ _____ I always tell someone where I am going and when I plan to return.

_____ _____ I always bring a map, compass, first aid kit, and emergency supplies.

_____ _____ I obtain weather information before any outdoor trip and dress appropriately.

_____ _____ I bring an adequate supply of fluids and limit strenuous activity during hot, humid weather.

_____ _____ I wear layers of warm clothing and covering for my head and hands when outdoors during cold weather.

_____ _____ I bring warm liquids and equipment for producing heat or starting fires if I will be outdoors for a prolonged period during cold weather.

Hunting/Fishing Safety

_____ _____ I take firearm safety and hunter safety courses regularly and follow all recommendations.

_____ _____ I keep firearms unloaded when they are not actively in use (including while hiking, crossing streams or ditches, or climbing over fences).

_____ _____ I am aware of others when casting or shooting.

_____ _____ I store equipment properly when it is not in use.

_____ _____ I store ammunition and firearms securely and separately.

Home Safety

_____ _____ Rugs and carpets are skid-proof.

_____ _____ Bathtubs have handrails and nonslip mats.

_____ _____ Floors are kept clear of conditions and objects that can cause slippage.

_____ Liquids _____ Sand or gravel

_____ Heavy wax coating _____ Small objects (e.g., toys)

_____ Electrical cords

(over)

Yes	No	
_____	_____	Stairs are maintained in a safe condition: _____ Well-lighted _____ With secure handrails or banisters _____ Kept clear
_____	_____	Ladders are sturdy and in good repair.
_____	_____	Cigarettes are extinguished and disposed of in ashtrays.
_____	_____	No one in the household smokes while in bed.
_____	_____	Electrical appliances, furnaces, and kerosene heaters are regularly checked to ensure proper functioning.
_____	_____	Portable heaters are used only when carefully monitored and are kept away from flammable items.
_____	_____	The residence is equipped with carbon monoxide detectors.
_____	_____	Electrical outlets are used correctly, not overloaded.
_____	_____	All floors in the residence are equipped with fire or smoke detectors.
_____	_____	Two fire escape routes have been planned ahead of time for every room, and each resident knows what route he or she should take.
_____	_____	Fire-extinguishing instruments are handy and in good working condition.
_____	_____	Residents know how to avoid excessive smoke inhalation and what to do if their clothes catch fire: (fill in) _____ _____
_____	_____	Medications are stored out of reach of children.
_____	_____	Cleaners, pesticides, and other dangerous and ingestible substances are stored correctly: _____ Out of reach of children _____ In their original containers
_____	_____	Cleaners, pesticides, and other dangerous substances are used only in areas with proper ventilation.
_____	_____	Residents know how to recognize the signs of poisoning.
_____	_____	Residents know what to do in case of poisoning.
_____	_____	Residents know whom to call in case of poisoning.
_____	_____	Residents are trained in: _____ First aid _____ CPR _____ Heimlich maneuver

IN CASE OF EMERGENCY, CALL_____

IN CASE OF POISONING, CALL (POISON CONTROL CENTER)_____

NATIONAL POISON CONTROL HOTLINE: 800-222-1222

Your answers here can help you identify behaviors that you should change. Consider planning a behavior change program to alter one or more of your risky behaviors. You will probably have more success eliminating risks from your home if you can get all residents to participate in your behavior change program.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 115

Driving Like a Pro

Along with safe cars, safety belts, air bags, and sobriety, driving skills are an important element in motor vehicle safety. Learn to drive defensively, avoiding dangerous situations and reacting intelligently in a crisis. To find out how well you drive already, try this defensive-driving quiz. (Some questions have more than one correct answer.)

1. The safest way to brake is
   a. as fast as possible.
   b. as far in advance as possible.

2. In moderate town traffic, with another car at a safe distance in front of you, you're being tailgated. What do you do?
   a. Tap the brakes and start to slow down—gradually—keeping an eye on the rearview mirror.
   b. Increase your speed to the allowable limit.
   c. Try to pass the car in front of you.
   d. Pull over to the right.

3. You are traveling 30 mph on a dry road. Safe following distance is
   a. 1 car length.
   b. 2 car lengths.
   c. 5 car lengths.

4. Preparing to change lanes on a multilane highway, which of the following should you do?
   a. Check your rearview mirror.
   b. Check your side mirror.
   c. Take your eyes off the road momentarily and glance at the lane you're planning to move into.
   d. Turn on your directional signal.
   e. Be aware of what traffic in front of you is doing.

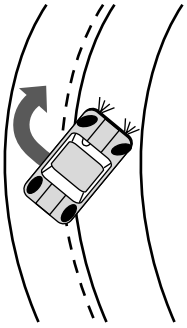
5. You've swerved to the right to avoid a collision on a two-way highway, and your right wheels drop off the pavement and are riding on the shoulder. To get back on the road, you
   a. accelerate, cutting the wheel to the left.
   b. don't brake but take your foot off the accelerator. Hold the wheel steady. When the car slows, check the traffic and steer back onto the pavement.
   c. brake sharply and try to pull off the road altogether. When you've got the car under control, pull onto the road again.

6. On a two-way highway, in what's clearly marked as a no-pass zone with limited visibility, a car pulls out to pass you. Your best move is to
   a. speed up, hoping the car will move back behind you.
   b. ignore the car—it's not your problem.
   c. reduce your speed so the car can get around you faster.

7. The most important factor in defensive driving is
   a. quick reflexes.
   b. anticipating trouble.
   c. skill at vehicle handling.
   d. strict observation of the law.

8. Which of the following road conditions up ahead should tell you to reduce your speed?
   a. a deep pothole
   b. leaves on the pavement
   c. any bridge when the temperature is just above freezing

9. Your rear-wheel-drive car is skidding (see diagram). What's the safest reaction?



   a. Turn the wheel to the right.
   b. Turn the wheel to the left.
   c. Brake as hard as possible and avoid turning the wheel until you've stopped the car.

(over)

10. In two-way highway traffic, an oncoming car suddenly pulls into your lane. What action do you take?
    a. Brake hard and sound your horn.
    b. Move quickly into the left lane.
    c. Blow your horn and head to the shoulder.

11. The best position for your hands on the steering wheel is
    a. at the 10:00 and 2:00 positions.
    b. at the 8:00 and 4:00 positions.
    c. wherever you're most comfortable.
    d. at the 9:00 and 3:00 positions.

12. True or false: Underinflated tires are safer, particularly in hot weather.

Answers

1. (b) A basic principle of defensive driving is never to get into a situation that calls for slamming on the brakes. This can throw you into a skid and injure you and your passengers.

2. (a) and (d), depending on circumstances. If the tailgater is daydreaming, tapping your brakes (and activating the brake lights) should wake him or her up. If the driver is being aggressive, you've politely given a signal to let up. If the tailgating doesn't stop, pull over as soon as you can and let the other car pass.

3. (c) On a dry road, going 30 mph, give yourself 2 to 3 seconds to stop, or about 5 car lengths. If you are driving faster, if the road is wet, if visibility is poor, or if you are tired, drop back more. To determine how close you are following, notice when the rear of the vehicle ahead passes a tree or other fixed point. Then count "one thousand one, one thousand two," and so on until you pass the same fixed point.

4. (all) All steps are essential, but some people forget (c). You always have a blind spot (about a car length behind you on either side) and may not be able to see an overtaking vehicle in either mirror. Always glance over your shoulder before making your move. The signal light turned on several seconds in advance will help protect you as well.

5. (b) Braking hard or jerking the wheel can cause you to skid into oncoming traffic. Don't brake but do reduce your speed and stay on a steady course. Then, after checking traffic, make a sharp quarter turn to the left to put yourself back on the road and then straighten out.

6. (c) Passing is always a cooperative venture. If this reckless driver has a head-on collision, you might be hurt too.

7. (b) Obeying the law and vehicle-handling skills are all important. But anticipating trouble up ahead and acting to prevent it can make the speed of your reflexes far less important and thus may prevent many collisions.

8. (all) The pothole may only jar you, but it could damage your car or even cause you to lose control. Leaves can send you into a skid. And even though there's no ice on the road, a bridge is about 6°F (3°C) colder than a highway and may be hazardous when the road is not.

9. (b) Turn the wheel straight down your lane. That is, if your rear wheels are skidding left, as in the diagram, turn with the skid—that is, to the left. Don't brake; it increases skidding.

10. (c) Don't move left, which could put you in someone else's pathway. Always move right when heading off the road.

11. (d) And some expert drivers recommend that you hook your thumbs lightly over the horizontal spokes. This gives you a feel for the front tires and is a good way to get a quick grip if you strike a pothole.

12. False. An underinflated tire is more likely to skid, whether in hot weather or on wet or icy pavement. Because underinflation allows a tire to "flap" slightly and thus to create more heat, it's also more likely to blow out. Even for desert driving, keep tires at the recommended maximum air pressure and check them weekly. The number should be printed on the side of the tires; or check the instruction manual if the car still has its original tires.

SOURCE: Adapted from Driving through the 90s. 1994. University of California at Berkeley *Wellness Letter,* July; and Driving like the pros. 1989. University of California at Berkeley *Wellness Letter,* October. Reprinted by permission from the University of California at Berkeley, *Wellness Letter*. Copyright © 1989, 1994 University Health Publishing Group, LLC. www.wellnessletter.com

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 116

Are You an Aggressive Driver?

To find out if you are an aggressive driver, check any of the following statements that are true for you:

_____ I consistently exceed the speed limit; I'm often unaware of both my speed and the speed limit.

_____ I frequently follow closely behind the car in front of me.

_____ If I feel the car in front of me is going too slowly, I tailgate.

_____ I change lanes frequently to pass people.

_____ I seldom use my turn signal when changing lanes or turning.

_____ I often run red lights or roll through stop signs.

_____ I react to what I feel is another driver's mistake by cursing, shouting, or making rude gestures; by blocking a car from passing or changing lanes; by using high beams; or by braking suddenly in front of a tailgater.

_____ My personality changes and I become more competitive when I get behind the wheel.

_____ I often get angry or impatient with other drivers and with pedestrians.

_____ I would consider pulling over for a personal encounter with a bad driver.

Each of these statements is characteristic of aggressive drivers; the more items you checked, the greater your road rage. If you checked even one statement, try the following steps to reduce your hostility the next time you get behind the wheel:

_____ Allow enough time for your trip to reach your destination without speeding.

_____ Avoid driving during periods of heavy traffic.

_____ Don't drive when you are angry, tired, or intoxicated.

_____ Imagine that the other drivers are all people that you know and like. Be courteous and forgiving.

_____ Listen to soothing music or a book on tape, or practice a relaxation technique such as deep breathing.

Develop at least two additional strategies that work for you:

1. _____

2. _____

If road rage is still a problem for you, take a course in anger management.

Even if you are successful at controlling your own aggressive driving impulses, you may still encounter an aggressive driver on the road. The AAA Foundation for Traffic Safety recommends the following strategies to avoid being a victim of an aggressive driver.

- Avoid behaviors that may enrage an aggressive driver; these include cutting cars off when merging, driving slowly in the left lane, tailgating, and making rude gestures.
- If you make a mistake while driving, apologize. In surveys, the most popular and widely understood gestures for apologies include raising or waving a hand and touching or knocking the head with the palm of your hand (to indicate "What was I thinking?").
- Refuse to join in a fight. Avoid eye contact with an angry driver, and put distance between your car and his or her vehicle. If you think another driver is following you or trying to start a fight, call the police on a cell phone or drive to a public place.

(over)

Think of two additional strategies for dealing with an aggressive driver:

1. _____

2. _____

INTERNET ACTIVITY

To further assess your risk for aggressive driving, take the quiz at the Web site for the AAA Foundation for Traffic Safety (http://www.aaafoundation.org/quizzes).

How did you score? Did the results indicate that aggressive driving may be a problem for you?

Research additional strategies for reducing your own road rage and for avoiding other aggressive drivers. Identify three strategies for avoiding problems associated with aggressive driving—your own or that of another driver. Visit one or more of the sites listed below or perform a search.

AAA Foundation for Traffic Safety: http://www.aaafoundation.org
Aggressive Driving Issues Conference: http://www.aggressive.drivers.com
National Highway Transportation Safety Administration: Aggressive Driving:
http://www.nhtsa.dot.gov/people/injury/enforce/adsped.htm
New York State Department of Motor Vehicles: Aggressive Driving:
http://www.nysgtsc.state.ny.us/aggr-ndx.htm

Site(s) visited (URL):_____

Strategies for reducing aggressive driving:

1. _____

_____

2. _____

_____

3. _____

_____

SOURCE: AAA Foundation for Traffic Safety. 1997. *Road Rage: How to Avoid Aggressive Driving.* Washington, D.C.: AAA Foundation for Traffic Safety.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 117

Personal Safety Checklist

Are you doing all you can to protect yourself from violence and injuries? The following list of statements relate to intentional injury incidents that can occur in a variety of settings. Put a check next to those statements that are true for you and fill in the requested information.

At Home

____ My home has good lighting.

____ Doors are secured with effective locks (deadbolts).

____ All unused doors and windows are securely locked.

____ I always lock all windows and doors when I go out.

____ I have a dog and/or post "Beware of Dog" signs.

____ Landscaping around the home doesn't provide opportunities for concealment.

____ Keys are hidden in a secure, nonobvious place.

____ I do not give anyone the opportunity to duplicate my keys.

____ The front door has a peephole.

____ I do not open my door to strangers or allow them into my home or yard.

____ I ask to see ID or call to verify that repair and utility workers are legitimate.

____ I use my initials in phone directory listings.

____ My answering machine message does not imply that I live alone or am not home.

____ Everyone in the household knows how to call for help.

____ My neighbors and I have a system for alerting one another in case of an emergency.

____ I participate in a neighborhood watch program.

On the Street

____ I avoid walking alone, especially at night or in less-populous areas.

____ I dress in clothing that allows freedom of movement.

____ I walk purposefully, in an alert and confident manner.

____ I walk on the outside of the sidewalk, facing traffic.

____ I check routes to my destination before leaving so as not to appear lost.

____ I never hitchhike.

____ I carry valuables in a secure or concealed location and take special care at ATMs.

____ I have my keys ready when I approach my vehicle or home.

____ I carry a cell phone or change for a public phone, fare for public transportation, and a whistle to blow if I am attacked or harassed.

____ I keep alert for suspicious behavior, and I keep at least two arm lengths between myself and strangers.

(over)

In My Car

____ My car is in good working condition.

____ I carry emergency supplies in my car.

____ I keep my gas tank at least half full.

____ When driving, I keep doors locked and windows rolled up at least three-quarters of the way.

____ I park my car in well-lighted areas or parking garages.

____ I lock my car when I leave it.

____ I check the interior of my car before unlocking it and getting in.

____ I don't pick up strangers.

____ I note the location of emergency call boxes, or I have a cell phone in my car.

____ I use caution if my car breaks down or if I am involved in a minor crash or bumped intentionally.

____ When I stop at a light or stop sign, I stop far enough behind the car in front to allow room to maneuver in case of emergency.

____ I do not get into arguments with drivers of other vehicles.

On Public Transportation

____ I wait in populated, well-lighted areas.

____ I sit near the driver or conductor.

____ I sit in a single seat or an outside seat.

____ I check routes and times in advance, and confirm before boarding that the bus, subway, or train is bound for my destination.

On Campus

____ The door and window locks where I live are secure.

____ The halls and stairwells where I live have adequate lighting.

____ Dorm doors are not left unlocked or propped open.

____ I do not give dorm or residence keys to others.

____ I keep my door locked.

____ I do not allow strangers into my room.

____ I do not walk, jog, or exercise alone at night.

____ I use campus escort services or walk with friends.

____ I know the areas that security guards patrol and stay where they can see or hear me if possible.

Your answers here can help you identify behaviors that you should change. Consider planning a behavior change strategy to alter one or more of your risky behaviors.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 118

Violence in Relationships

Part I. Recognizing the Potential for Abusiveness

If you are concerned that a man you are involved with has the potential for violence, observe his behavior and ask yourself these questions.

1. What is this person's attitude toward women? How does he treat his mother and his sister? How does he work with female students, female colleagues, or a female boss? How does he treat your women friends?

2. What is his attitude toward your autonomy? Does he respect the work you do and the way you do it? Or does he put it down, or tell you how to do it better, or encourage you to give it up? Does he tell you he'll take care of you?

3. How self-centered is he? Does he want to spend leisure time on your interests or his? Does he listen to you? Does he remember what you say?

4. Is he possessive or jealous? Does he want to spend every minute with you? Does he cross-examine you about things you do when you're not with him?

5. What happens when things don't go the way he wants them to? Does he blow up? Does he always have to get his way?

6. Is he moody, mocking, critical, or bossy? Do you feel as if you're "walking on eggshells" when you're with him?

7. Do you feel you have to avoid arguing with him?

8. Does he drink too much or use drugs?

9. Does he refuse to use condoms or take other precautions for safer sex?

(over)

Experts summarize their advice to women this way: Listen to your own uneasiness, and stay away from any man who disrespects women, who wants or needs you intensely and exclusively, and who has a knack for getting his own way almost all the time.

Part II. Recognizing Signs of Abuse

Yes	No	
_____	_____	1. Does your partner constantly criticize you, blame you for things that are not your fault, or verbally degrade you?
_____	_____	2. Does he humiliate you in front of others?
_____	_____	3. Is he suspicious or jealous? Does he accuse you of being unfaithful or monitor your mail or phone calls?
_____	_____	4. Does he "track" all your time? Does he discourage you from seeing friends and family?
_____	_____	5. Does he prevent you from getting or keeping a job or attending school? Does he control your shared resources or restrict your access to money?
_____	_____	6. Has he ever pushed, slapped, hit, kicked, bitten, or restrained you? Thrown an object at you? Used a weapon on you?
_____	_____	7. Has he ever destroyed or damaged your personal property or sentimental items?
_____	_____	8. Has he ever forced you to have sex or to do something sexually you didn't want to do?
_____	_____	9. Does he anger easily when drinking or taking drugs?
_____	_____	10. Has he ever threatened to harm you or your children, friends, pets, or property?
_____	_____	11. Has he ever threatened to blackmail you if you leave?

If you answered "yes" to one or more of these questions, you may be experiencing domestic abuse. If you believe you or your children are in imminent danger, look in your local telephone directory for a women's shelter, or call 9-1-1. If you want information, referrals to a program in your area, or assistance, contact one of the organizations listed in For More Information in Chapter 21 of your textbook (Chapter 16 in the brief version).

INTERNET ACTIVITY

Research Web resources relating to date rape or domestic violence; use the Web sites listed in your text and/or do a Web search. What resources are available for victims and abusers? Are referrals to support groups or legal help provided? Are there suggestions for friends of victims or concerned citizens and communities? Write a brief description of the most helpful site you locate.

Topic: _____

Site visited (URL): _____

Description:

SOURCES: Family Violence Prevention Fund. 1996. *Take Action Against Domestic Violence.* San Francisco, Calif.: Family Violence Prevention Fund; How to tell if you're in an abusive situation. 1994. *San Francisco Chronicle,* 24 June; Jones, A. 1994. *Next Time She'll Be Dead.* Boston: Beacon Press.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 119

Warning Signs of Violence and Techniques for Managing Anger

Recognizing Warning Signs of Violence in Others

Often people who act violently have trouble controlling their feelings. They may have been hurt by others. Some think that making people fear them through violence or threats of violence will solve their problems or earn them respect. This isn't true. People who behave violently lose respect. They find themselves isolated or disliked, and they still feel angry and frustrated. One way to address the problem of violence is to learn to recognize and react to potential signs of violent behavior. If you notice the following signs over a period of time, the potential for violence exists (check any that apply).

_____ A history of violent or aggressive behavior

_____ Serious drug or alcohol use

_____ Gang membership or a strong desire to be in a gang

_____ Access to or fascination with weapons, especially guns

_____ Threatening others regularly

_____ Trouble controlling feelings like anger

_____ Withdrawal from friends and usual activities

_____ Feeling rejected or alone

_____ Having been a victim of bullying

_____ Poor school performance

_____ A history of discipline problems or frequent run-ins with authority

_____ Feeling constantly disrespected

_____ Failing to acknowledge the feelings or rights of others

If you see these immediate warning signs, violence is a serious possibility:

_____ Loss of temper on a daily basis

_____ Frequent physical fighting

_____ Significant vandalism or property damage

_____ Increase in use of drugs or alcohol

_____ Increase in risk-taking behavior

_____ Detailed plans to commit acts of violence

_____ Announcing threats or plans for hurting others

_____ Enjoying hurting animals

_____ Carrying a weapon

If someone you know shows warning signs of violence, there are things you can do. Above all, be safe. Don't spend time alone with people who show warning signs. If possible without putting yourself in danger, remove the person from the situation that's setting him or her off. Tell someone you trust and respect about your concerns and ask for help. This could be a family member, guidance counselor, teacher, school psychologist, coach, clergy, school resource officer, or friend. If you are worried about being a victim of violence, get someone in authority to protect you. Do not resort to violence or use a weapon to protect yourself.

Controlling Your Own Risk for Violent Behavior

Complete the checklist for your own behavior. If you recognize any of the warning signs for violent behavior in yourself, get help. You don't have to live with the guilt, sadness, and frustration that comes from hurting others. Admitting you have a concern about hurting others is the first step. The second is to talk to a trusted person such as a school counselor or psychologist, teacher, family member, friend, or clergy. They can get you in touch with a licensed mental health professional who can help.

It's normal to feel angry or frustrated when you've been let down or betrayed. But anger and frustration don't justify violent action. Anger is a strong emotion that can be difficult to keep in check, but the right response is always to stay cool. Try the following methods of dealing with anger without resorting to violence:

(over)

_____ Learn to talk about your feelings—if you're afraid to talk or if you can't find the right words to describe what you're going through, find a trusted friend or adult to help you one-on-one.

_____ Express yourself calmly—express criticism, disappointment, anger, or displeasure without losing your temper or fighting. Ask yourself if your response is safe and reasonable.

_____ Listen to others—listen carefully and respond without getting upset when someone gives you negative feedback. Ask yourself if you can really see the other person's point of view.

_____ Negotiate—work out your problems with someone else by looking at alternative solutions and compromises.

Everyone feels anger in his or her own way. Start managing it by recognizing how anger feels to you. When you are angry, you probably feel muscle tension, accelerated heartbeat, a "knot" or "butterflies" in your stomach, changes in your breathing, trembling, goose bumps, and flushed in the face. You can reduce the rush of adrenaline that's responsible for your heart beating faster, your voice sounding louder, and your fists clenching if you try the following:

_____ Take a few slow, deep breaths and concentrate on your breathing.

_____ Imagine yourself at the beach, by a lake, or anywhere that makes you feel calm and peaceful.

_____ Try other thoughts or actions that have helped you relax in the past.

_____ Keep telling yourself "Calm down," "I don't need to prove myself," or "I'm not going to let him/her get to me."

Stop. Consider the consequences. Think before you act. Only you have the power to control your own violent behavior; don't let anger control you.

INTERNET ACTIVITY

Choose one type of violence to investigate, and write a brief description of current U.S. trends. How common is this type of violence? What are the typical characteristics of perpetrators and victims? Is this type of violence increasing or decreasing? What are some of the risk factors associated with it? Use the sites listed in your text or perform a search. Statistics and background information on many types of violence in the United States are available at the following sites:

Bureau of Justice Statistics: http://www.ojp.usdoj.gov/bjs
Federal Bureau of Investigation: http://www.fbi.gov
National Criminal Justice Reference Service:

Site(s) visited (URL):_____

Type of violence: _____

Discussion:

SOURCE: Recognizing Warning Signs of Violence in Others, Controlling Your Own Risk for Violent Behavior, and the methods for dealing with anger have been adapted from "Warning Signs of Youth Violence." Copyright © 2004 by the American Psychological Association. Adapted with permission. See http://apahelpcenter.org to view the full document and for other information on psychological issues affecting physical and emotional well-being. No further reproduction or distribution is permitted without written permission from the American Psychological Association.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 120

Building a Kit of Emergency Supplies for Your Household

A kit with the supplies listed below can help you and those in your household prepare for both natural and man-made emergencies. Check off items as you add them to your kit. Keep your kit in a designated place so that you can retrieve it quickly in case you need to be evacuated. Put together a smaller kit to keep in your car and at your place of work.

Basic Emergency Supplies

____ Map of the area for help in evacuating or locating shelters

____ Cash (including change) and credit cards

____ Copies of important documents (stored in a watertight container)

____ Emergency contact list and phone numbers

____ Extra sets of house and car keys

____ Flashlight

____ Battery- or solar-powered radio

____ Battery-powered alarm clock

____ Extra batteries

____ Cell phone and/or prepaid phone card

____ Signal flares

____ Fire extinguisher (small canister A-B-C type)

____ Whistle

____ Tube tent

____ Sleeping bags or warm blankets (one per person)

____ Complete change of warm clothing and footwear (jacket or coat, long pants, long-sleeved shirt, sturdy shoes, hat, gloves, raingear, extra socks and underwear, sunglasses)

____ Work gloves

____ Pliers

____ Shut-off wrench for gas and water supplies

____ Shovel, hammer, and other tools

____ Compass

____ Matches in a waterproof container

____ Aluminum foil

____ Plastic storage containers

____ Duct tape and scissors

____ Paper, pens, pencils

____ Needles and thread

____ Medicine dropper

(over)

First Aid Kit

____ First aid manual
____ Thermometer
____ Scissors
____ Tweezers
____ Safety pins
____ Needle
____ Latex or other sterile gloves
____ Sterile gauze pads
____ Cleansing agent (soap, isopropyl alcohol, or antiseptic towelettes)
____ Sunscreen
____ Antibiotic ointment
____ Burn ointment
____ Petroleum jelly or another lubricant
____ Sterile adhesive bandages in several sizes
____ Sterile roller bandages
____ Triangular bandages
____ Cotton balls
____ Eyewash solution
____ Aspirin or nonaspirin pain reliever
____ Antidiarrhea medication
____ Laxative
____ Antacid
____ Activated charcoal (use if advised by Poison Control Center)
____ Potassium iodide (use following radiation exposure if advised by local health authorities)
____ Prescription medications and prescribed medical supplies
____ List of medications, dosages, and any allergies (for each household member)

Special Needs Items

____ Infant care needs (formula, bottles, diapers, powdered milk, diaper rash ointment)
____ Extra eye glasses
____ Contact lenses and supplies
____ Denture needs
____ Hearing aid or wheelchair batteries; other special equipment

(over)

____ Pet care supplies

____ Other (list): _____

____ Other (list): _____

Food and Related Supplies

____ Manual (non-electric) can opener

____ Utility knife

____ Eating utensils: Mess kits, or paper cups and plates and plastic utensils

____ Sugar, salt, pepper

____ Paper towels

____ Plastic garbage bags and resealing bags

____ Small cooking stove and cooking fuel (if food must be cooked)

____ Water: Three-day supply, at least one gallon of water per person per day, stored in clean plastic containers such as soft drink bottles:

Number of people: _____ × 1 gallon/day × 3 days = ____ Total minimum gallons of water

Store additional water if you live in a hot climate or if your household includes infants, pregnant women, or people with special health needs. Containers can be sterilized by rinsing them with a diluted bleach solution (one part beach to ten parts water). Replace your water supply every 6 months.

____ Food: At least a 3-day supply of nonperishable foods—those requiring no refrigeration, preparation, or cooking and little or no water. Choose foods from the following checklist and expand the list with foods that members of your household will eat. Replace items in your food supply every 6 months

	Ready-to-eat canned meats, fruits, and vegetables		Comfort/stress foods
	Protein or fruit bars		Vitamins
	Dry cereal or granola		Infant foods
	Peanut butter		Pet foods
	Dried fruit		Other:
	Nuts		Other:
	Crackers		Other:
	Canned or boxed juices		Other:
	Nonperishable pasteurized milk or powdered milk		Other:
	High-energy foods		Other:

Sanitation

____ Plastic garbage bags (and ties)

____ Toilet paper

____ Moist towelettes

(over)

____ Washcloth and towel

____ Personal hygiene items (toothbrush, shampoo, deodorant, comb, shaving cream, and so on)

____ Plastic bucket with tight lid

____ Disinfectant

____ Household chlorine bleach

____ If possible, a small shovel for digging a latrine

For a Clean Air Supply

____ Face masks OR several layers of dense-weave cotton material (handkerchiefs, t-shirts, towels) that fit snugly over your nose and mouth. Each household member should have his or her own nose and mouth protection that fits tightly to help filter out contaminants.

____ Shelter-in-place supplies, to be used in an interior room in your home to create a barrier between you and potentially contaminated air outside.

- ____ Heavyweight plastic garbage bags or plastic sheeting
- ____ Duct tape
- ____ Scissors
- ____ If possible, a portable air purifier with a HEPA filter

Family Emergency Plan

_____ Plan places where your family will meet; choose one location near your home and one outside your neighborhood.

Local: _____

Outside neighborhood: _____

____ Make sure children know where to go or whom to contact in case of an emergency.

____ Post emergency numbers and instructions.

____ Have one local and one out-of-state contact person for family members to call if separated during a disaster. (It may be easier to make long-distance calls than local calls.)

Local: _____

Out-of-state: _____

____ Know how to shut off water, gas, and electricity; keep the necessary tools near the shut-off valves.

____ Talk with your neighbors: Who has specialized equipment (for example, a power generator) or expertise that might help in a crisis? Do elderly or disabled neighbors have someone to help them?

____ Take a first aid class.

SOURCES: U.S. Department of Homeland Security: Ready.Gov (http://www.ready.gov); Federal Emergency Management Agency (http://www.fema.gov).

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 121

Are You Prepared for Aging?

Assess Your Current Behaviors

Are you doing everything you can now to enhance the quality of your life as you age? Read through the following list of statements and check the answer that best describes your current behavior.

Yes	No	
____	____	I exercise regularly.
____	____	I eat wisely.
		____ I eat meals low in fat and added sugars and high in essential nutrients and fiber (fresh fruits and vegetables, whole-grain cereals and breads, brown rice, pasta).
		____ I limit saturated and trans fats and get protein from fish, skinless poultry, and plant sources.
		____ I use fat-free or low-fat dairy products.
		____ I consume the recommended amount of calcium, vitamin D, and vitamin B-12.
		____ I limit the amount of sodium I consume and consume adequate potassium.
____	____	My weight is in the recommended range.
____	____	I drink alcohol in moderation, if at all.
____	____	I don't use tobacco in any form.
____	____	I recognize the stressors in my life and take appropriate steps to control and deal with stress.
____	____	I perform appropriate self-examinations.
____	____	I have regular physical examinations that include appropriate screening tests.
____	____	I participate in activities that keep my mind sharp and active.

Thinking About Aging

Have you thought seriously about the changes that aging can bring? To help you begin thinking now about your life as you grow older, answer the following questions:

1. What things come to mind when you think of an older person? Can you imagine those things applying to you? What do you think you will be like when you are 70 years old?

2. What do you most look forward to as you grow older?

(over)

3. What do you most fear as you grow older?

4. How long would you like to keep working? What would you like to do after you retire? What hobbies or volunteer opportunities would you pursue?

5. Have you considered the loss of income that retirement often brings? What can you do now to help meet your economic needs in the future?

6. Older people often find themselves alone more frequently (due to the death of a spouse and/or close friends). Can you think of activities you enjoy doing alone?

7. If when you are older you are no longer able to care for yourself, what living and care arrangements would you prefer?

8. What would you do if your parents were no longer able to care for themselves?

9. List five positive and five negative things about aging.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 122

The Eight Dimensions of Successful Retirement Self-Assessment

Throughout our lives we have passed through many stages of development and change. This self-assessment has been created to help you explore and reflect upon eight life dimensions that are related to a successful retirement. There are no right or wrong answers.

Instructions: Review each item within each of the Eight Dimensions and circle the number, from 0 (lowest) to 5 (highest), that best reflects your current level of satisfaction with that item.

A comments section has been included with each dimension for you to include additional thoughts and reflections after you have completed the exercise.

Dimension 1 : Self-Discovery & Renewal

1. Level of spirituality	0	1	2	3	4	5
2. Commitment to personal core values	0	1	2	3	4	5
3. Self-maintenance and development activities	0	1	2	3	4	5
4. Personal focus and search for meaning	0	1	2	3	4	5
5. Development of new skills and interests	0	1	2	3	4	5

Comments: _____

_____

Dimension 2: Financial & Legal Stewardship

1. Current financial resources	0	1	2	3	4	5
2. Future financial resources	0	1	2	3	4	5
3. Financial planning, goals and objectives	0	1	2	3	4	5
4. Relationship of other goals with financial resources	0	1	2	3	4	5
5. Asset and health care protection	0	1	2	3	4	5

Comments: _____

_____

(over)

Dimension 3: Health & Wellness

1. Diet and nutrition	0	1	2	3	4	5
2. Level of exercise/physical activity	0	1	2	3	4	5
3. Health appraisal	0	1	2	3	4	5
4. Goals and objectives	0	1	2	3	4	5
5. Factors affecting health (smoking, alcohol, drugs, etc.)	0	1	2	3	4	5

Comments: _____

_____

Dimension 4: Meaning & Purpose—Continuing to Contribute

1. Volunteer activities	0	1	2	3	4	5
2. Working—full or part time	0	1	2	3	4	5
3. Service organization involvement	0	1	2	3	4	5
4. Family support and involvement	0	1	2	3	4	5
5. Feeling of meaning and purpose	0	1	2	3	4	5

Comments: _____

_____

Dimension 5: Staying Sharp—Mental Fitness

1. Continuing to learn	0	1	2	3	4	5
2. Self-esteem	0	1	2	3	4	5
3. Exploring new opportunities	0	1	2	3	4	5
4. Future outlook	0	1	2	3	4	5
5. Personal goals and objectives	0	1	2	3	4	5

Comments: _____

_____

(over)

Dimension 6: Relationships

1. Quality of interactions with family members	0	1	2	3	4	5
2. Quantity of interactions with family members	0	1	2	3	4	5
3. Quality of interactions with others	0	1	2	3	4	5
4. Quantity of interactions with others	0	1	2	3	4	5
5. Connections with other groups	0	1	2	3	4	5

Comments: _____

_____

Dimension 7: Peak Experiences

1. Hobbies	0	1	2	3	4	5
2. Travel	0	1	2	3	4	5
3. Sports and related activities	0	1	2	3	4	5
4. Cultural activities	0	1	2	3	4	5
5. Clubs, associations, group membership	0	1	2	3	4	5

Comments: _____

_____

Dimension 8: Home Base

1. Geographical preference	0	1	2	3	4	5
2. Suitability/type of residence	0	1	2	3	4	5
3. Access to resources and activities	0	1	2	3	4	5
4. Climate	0	1	2	3	4	5
5. Congruity with financial resources	0	1	2	3	4	5

Comments: _____

_____

(over)

Scoring Instructions:

1. Add your "scores" for each item within each dimension to get a total score for that dimension. Record your score for each dimension below.
2. Divide that total by 5 to get an average score for the dimension.
3. List the average score for each dimension in the chart below.

Dimension	Total Score	Avg. Score (Total ÷ 5)
1. Self-Discovery & Renewal	_____	_____
2. Financial & Legal Stewardship	_____	_____
3. Health & Wellness	_____	_____
4. Continuing to Contribute	_____	_____
5 . Mental Fitness	_____	_____
6. Relationships	_____	_____
7. Peak Experiences	_____	_____
8. Home Base	_____	_____

4. Plot your Average Satisfaction Scores on the following line chart.

5								
4								
3								
2								
1								
	D-1	D-2	D-3	D-4	D-5	D-6	D-7	D-8

5. Connect the dots with straight lines to complete your line chart.

SOURCE: Eckerd College. 2005. *Charting Your Course to Successful Retirement* (www.eckerd.edu/lifelong/index.php?f=home; retrieved January 12, 2007). Copyright 2005 Eckerd College, St. Petersburg, FL. Reprinted with permission of James E. Frasier.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 123

Osteoporosis

Part I. Osteoporosis Risk Assessment

Complete the following questionnaire to determine your risk for developing osteoporosis.

Yes	No	
_____	_____	1. Do you have a small, thin frame?
_____	_____	2. Have you or a member of your immediate family broken a bone as an adult?
_____	_____	3. Are you a postmenopausal woman?
_____	_____	4. Have you had an early or surgically-induced menopause?
_____	_____	5. Have you taken high doses of thyroid medication or used glucocorticoids ≥ 5 mg a day (for example, prednisone) for 3 or more months?
_____	_____	6. Have you taken, or are you taking, immunosuppressive medications or chemotherapy to treat cancer?
_____	_____	7. Is your diet low in dairy products and other sources of calcium?
_____	_____	8. Are you physically inactive?
_____	_____	9. Do you smoke cigarettes or drink alcohol in excess?

The more times you answer "yes," the greater your risk for developing osteoporosis. See your health care provider, and visit the National Osteoporosis Foundation (NOF) Web site at www.nof.org for more information.

Part II. Do You Get Enough Calcium?

Write in the number of servings of each of the following types of calcium-rich foods you eat on an average day. Typical serving sizes are given for each.

High Calcium-Rich Foods

Milk and Milk Products
_____ nonfat or low-fat milk or buttermilk (1 cup)
_____ low-fat chocolate milk (1 cup)
_____ reduced-fat milk, unflavored or chocolate (1 cup)
_____ nonfat, low-fat, or regular yogurt (1 cup)
_____ low-fat cheese or mozzarella (1 1/2 oz)
_____ whole milk, unflavored or chocolate (1 cup)
_____ milkshake made with milk (1 cup)
_____ hot chocolate made with milk (1 cup)
_____ pudding, custard, or flan, made with milk (1 cup)
_____ blended coffee drinks, e.g. lattes or mochas (1 1/2 cup)
_____ hard cheese (1 1/2 oz)
_____ processed cheese (2 oz)

Meat, Beans, and Nuts
_____ tofu processed with calcium (1/2 cup)
_____ sardines with bones (6)

_____ **Total servings of high calcium-rich foods**

Medium Calcium-Rich Foods

Milk and Milk Products
_____ nonfat, low-fat, or regular cottage cheese (1/2 cup)
_____ cream soup (1 cup)
_____ ice milk, frozen yogurt, or ice cream (1/2 cup)
_____ sour cream (1/4 cup)

Meats, Beans, and Nuts
_____ dried beans, peas, or refried beans (1 cup)
_____ canned fish with bones (2 oz)
_____ almonds (1/4 cup)

Vegetables & Fruits
_____ bok choy (1/2 cup)
_____ broccoli (1 cup)
_____ kale (1 cup)
_____ mustard greens (1 cup)
_____ turnip greens (1/2 cup)
_____ figs (5)

Breads and Grains
_____ corn tortillas (2)

_____ **Total servings of medium calcium-rich foods**

Three servings of medium calcium-rich foods equal one high calcium-rich serving, so divide the total servings of medium calcium-rich foods by 3 before totaling your daily servings:

_____ servings of high calcium-rich foods + (_____ servings of medium calcium-rich foods ÷ 3)
= _____ total calcium servings

2–3 total servings = about 1000–1200 mg of calcium
3–4 total servings = about 1200–1500 mg of calcium

Refer to the Nutrition Resources section in your text, and fill in the calcium recommendation for people of your sex and age: _____ mg calcium/day

How does your intake compare? If it's too low, consider planning a behavior change strategy that focuses on increasing calcium intake. Once you have a better idea of how many servings of calcium-rich foods you should consume, you can do a quick online calcium intake check by taking the Calcium Quiz at the Web site for the Dairy Council of California (http://www.dairycouncilofca.org); click on "Tools" from the home page.

INTERNET ACTIVITY

Choose one of the potential physical challenges of growing older—osteoporosis, arthritis, hearing loss, Alzheimer's disease, glaucoma, and so on; if possible, choose one that has affected a member of your family or someone you know. Do a Web search to identify strategies for both preventing the problem and coping with the problem if it does occur. (Coping strategies can apply to either the affected person or to her or his caregivers.)

Challenge/problem:

Site(s) visited (URL):

Strategies for prevention (list at least three):

Strategies for coping (list at least three):

SOURCES: Part I from National Osteoporosis Foundation. 2008. From *Osteoporosis: Can it Happen to You?* Copyright 2008 National Osteoporosis Foundation, Washington, DC 20036. Reprinted with permission. Part II from Dairy Council of California. 1994. *The Calcium Connection: Healthy Bodies from One Generation to Another.* Copyright © 1994 Revised 2008 Dairy Council of California. Reprinted with permission.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 124

Your Experiences and Attitudes About Death

Learning to accept and deal with death is a difficult but important part of life. Examine your past experiences with and attitudes about death by answering the questions below. Circle the answer that best describes your experiences or attitudes and fill in the requested information.

1. Who died in your first personal involvement with death?
   a. Grandparent or great-grandparent
   b. Parent
   c. Brother or sister
   d. Other family member
   e. Friend or acquaintance
   f. Stranger
   g. Public figure
   h. Animal

2. To the best of your memory, at what age were you first aware of death?
   a. Under 3 years
   b. 3 to 5 years
   c. 5 to 10 years
   d. Ten years or older

3. When you were a child, how was death talked about in your family?
   a. Openly
   b. With some sense of discomfort
   c. Only when necessary and then with an attempt to exclude the children
   d. As though it were a taboo subject
   e. Never recall any discussion

4. Which of the following best describes your childhood conceptions of death?
   a. Heaven and hell concept
   b. Afterlife
   c. Death as sleep
   d. Cessation of all physical and mental activity
   e. Mysterious and unknowable
   f. Something other than the above
   g. No conception
   h. Can't remember

5. Which of the following most influenced your present attitudes toward death?
   a. Death of someone close
   b. Specific reading
   c. Religious upbringing
   d. Introspection and meditation
   e. Ritual (e.g., funerals)
   f. TV, radio, or motion pictures
   g. Longevity of my family
   h. My health or physical condition
   i. Other (specify): _____
   _____

6. To what extent do you believe in a life after death?
   a. Strongly believe in it
   b. Tend to believe in it
   c. Uncertain
   d. Tend to doubt it
   e. Convinced it does not exist

7. Regardless of your belief about life after death, what is your wish about it?
   a. I strongly wish there were a life after death.
   b. I am indifferent as to whether there is a life after death.
   c. I definitely prefer that there not be a life after death.

8. How often do you think about your own death?
   a. Very frequently (at least once a day)
   b. Frequently
   c. Occasionally
   d. Rarely (no more than once a year)
   e. Very rarely or never

9. If you could choose, when would you die?
   a. In youth
   b. In the middle prime of life
   c. Just after the prime of life
   d. In old age

(over)

10. When do you believe that, in fact, you will die?
    a. In youth
    b. In the middle prime of life
    c. Just after the prime of life
    d. In old age

11. Has there been a time in your life when you wanted to die?
    a. Yes, mainly because of great physical pain
    b. Yes, mainly because of great emotional pain
    c. Yes, mainly to escape an intolerable social or interpersonal situation
    d. Yes, mainly because of great embarrassment
    e. Yes, for a reason other than above
    f. No

12. What does death mean to you?
    a. The end; the final process of life
    b. The beginning of a life after death; a transition, a new beginning
    c. A joining of the spirit with a universal cosmic consciousness
    d. A kind of endless sleep; rest and peace
    e. Termination of this life but with survival of the spirit
    f. Don't know
    g. Other (specify): _____
    _____

13. What aspect of your own death is the most distasteful to you?
    a. I could no longer have any experience.
    b. I am afraid of what might happen to my body after death.
    c. I am uncertain as to what might happen to me if there is a life after death.
    d. I could no longer provide for my family.
    e. It would cause grief to my relatives and friends.
    f. All my plans and projects would come to an end.
    g. The process of dying might be painful.
    h. Other (specify): _____
    _____

14. In your opinion, at what age are people most afraid of death?
    a. Up to 12 years
    b. 13 to 19 years
    c. 20 to 29 years
    d. 30 to 39 years
    e. 40 to 49 years
    f. 50 to 59 years
    g. 60 to 69 years
    h. 70 years and over

15. When you think of your own death or when circumstances make you aware of your own mortality, how do you feel?
    a. Fearful
    b. Discouraged
    c. Depressed
    d. Purposeless
    e. Resolved, in relation to life
    f. Pleasure, in being alive
    g. Other (specify): _____
    _____

16. To what extent are you interested in having your image survive after your own death through your children, books, good works, and so on?
    a. Very interested
    b. Moderately interested
    c. Somewhat interested
    d. Not very interested
    e. Totally uninterested

17. If you had a choice, what kind of death would you prefer?
    a. Tragic, violent death
    b. Sudden but not violent death
    c. Quiet, dignified death
    d. Death in line of duty
    e. Death after a great achievement
    f. Suicide
    g. Homicide
    h. There is no "appropriate" kind
    i. Other (specify): _____
    _____

18. If it were possible, would you want to know the exact date on which you are going to die?
    a. Yes
    b. No

(over)

19. How important do you believe mourning and grief ritual (such as wakes and funerals) are for the survivors?
    a. Extremely important
    b. Somewhat important
    c. Undecided or don't know
    d. Not very important
    e. Not important at all

20. If it were entirely up to you, how would you like to have your body disposed of after you have died?
    a. Burial
    b. Cremation
    c. Donation to medical school or science
    d. I am indifferent

21. What kind of a funeral would you prefer?
    a. Formal, as large as possible
    b. Small, relatives and close friends only
    c. Whatever my survivors want
    d. None

22. How do you feel about "lying in state" in an open casket at your funeral?
    a. Approve
    b. Don't care one way or the other
    c. Disapprove
    d. Strongly disapprove

23. Who do you feel should be the one to tell you that you are dying?
    a. Physician
    b. Nurse
    c. Family member
    d. Close friend

24. Which aspect of yourself would you want to take time with if you knew you would die soon? Rate 1–l0 for urgency, 1 being most urgent.
    a. Physical
    b. Emotional
    c. Activities and plans
    d. Spiritual
    e. Relationships
    f. Playful
    g. Financial and practical
    h. Other (specify): _____
    _____

25. List four things you would most like to learn, change, or do before you die. Number 1 through 4 in priority.
    _____
    _____
    _____
    _____

26. Which rituals or activities do you feel may be helpful for survivors and their grief process? Mark V = Very helpful, M = Moderately helpful, Q = Questionable, N = Not helpful, D = Detrimental
    a. Embalming, open casket
    b. Viewing body, not embalmed
    c. Memorial service
    d. Getting rid of photos and belongings
    e. Taking trip later
    f. Remembering dead on anniversary, holidays
    g. Talking about deceased a lot
    h. New social activities, dating
    i. Wearing black
    j. Taking a trip right away
    k. Restricting social activities
    l. Keeping belongings
    m. Moving, selling house (when not necessary)
    n. Joining grief support groups
    o. Grieving alone
    p. Sharing grief with children
    q. Suggested activities not mentioned:
    _____
    _____
    _____
    _____

27. Most often, how do you feel you probably will die?
    a. Long illness
    b. Stroke or heart attack
    c. Auto crash
    d. War
    e. Violent encounter
    f. Other (specify): _____
    _____

(over)

28. What is your most vivid experience with death?
    Age: _____
    a. Dream
    b. Experience with close person
    c. Animal
    d. Experience with stranger
    e. Story
    f. News story
    If your answer was (a), (c), or (f), briefly describe: _____
    _____

29. How is death talked about in your family at this time?
    a. Openly
    b. Some discomfort
    c. Only when necessary
    d. Excludes children
    e. Taboo
    f. Never recall talking
    g. Excludes dying person or survivor

30. At what age did you experience the most fear of death? _____
    Do you know what was on your mind then?
    _____

31. If you had a terminal illness, who would you want to talk with about your "difficult" feelings? (Number in preferential order):
    a. Spouse
    b. Close family member
    c. Physician
    d. Another patient
    e. Friend
    f. Nurse
    g. Therapist
    h. Clergy or spiritual friend
    i. Understanding third party

32. If a physician told you that an immediate family member was going to die, would you want them told?
    a. Yes
    b. No
    c. Depends

33. If your close friend was dying, felt depressed, and wanted to talk, how would you feel?
    a. Comfortable
    b. Embarrassed
    c. Distressed
    d. Willing
    e. Not sure
    f. Would visit less

34. When thinking of dying, I mostly fear (Rate H = High fear, M = Moderate fear, L = Low fear):
    a. Being alone
    b. Mentally disoriented
    c. Pain
    d. Disfigurement
    e. Dependence on others
    f. Loss of control over physical functions
    g. What happens at/after death
    h. Hospitalization for treatment
    i. Other (specify): _____
    _____

35. When notified of a funeral—not immediate family—I usually:
    a. Decline
    b. Hate to go
    c. Happy to go
    d. Attend if at all possible
    e. Dread going

36. The cause of death I'm most afraid of is:
    a. Accident
    b. Cancer
    c. Bomb
    d. Infection
    e. Nerve disease
    f. Heart failure
    g. Kidney failure
    h. Stroke
    i. Violence
    j. Other (specify): _____
    _____

SOURCE: From Edwin S. Shneidman. 1970. A *Psychology Today* questionnaire: You and death. *Psychology Today,* August. Reprinted with permission from *Psychology Today* magazine. Copyright © 1970 Sussex Publishers, LLC.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 125

Planning for Death

Once you acknowledge the inevitability of death, you can plan for it and ease what might later be hard decisions for both your survivors and yourself. Some decisions can and should be made early so that an unexpected death is not made even more difficult for family and friends. Think about plans you can make for your own death by answering the questions below.

1. *Make a will.* You should make out a will when you reach the age of majority. It should include specific instructions about how to dispose of your property. List ten possessions in the space below and indicate whom they should go to in the event of your death:

List any money or investments you have (bank accounts, certificates of deposit, 401(k) accounts, etc.). Who would this money go to? How should it be divided?

If applicable, create some general guidelines for your executor regarding children or ongoing business investments:

(over)

2. *Decide what to do with the body.* Would you prefer your body to be embalmed or not, buried, cremated, given to medicine for research, or prepared for donating organs? What are the reasons for your choice? If you decide to donate organs, complete a Uniform Donor Card and carry it in your wallet.

3. *Plan a ceremony.* What type of ceremony would you prefer? If you choose to have a gravestone, what would you want it to say? If you have chosen cremation, what would you like done with the ashes?

4. *Choose where to die.* If death is not sudden and you have a choice, where would you prefer to spend your last days (home, hospital, hospice)? Consider the effects of your choice on you, your family, and your finances.

Name _____ Section _____ Date _____

WELLNESS WORKSHEET 126

Advance Medical Directives

You can obtain a standard advance directive for your state from a local hospital, a state health department, or the not-for-profit National Hospice and Palliative Care Organization (1700 Diagonal Road, Suite 625, Alexandria, VA, 22314; 703-837-1500; www.nhpco.org). The state forms are not very specific, and you may increase the chance of a physician following your wishes if you provide more detailed instructions. The form shown below allows you to make specific choices about medical procedures under six different circumstances.

This form expresses my specific wishes regarding medical treatments in case illness prevents me from communicating them directly. My wishes apply both to the illness described and to any other situations that might develop. If a circumstance arises that my choices do not specifically address, my doctors and my agent should extrapolate from my choices below to the situation at hand. I understand that my wishes must be medically reasonable. Finally, all conclusions about my medical condition must be agreed to by my physician and appropriate consultants.

For each of the situations at right, check the boxes that indicate your wishes regarding treatment.	**Situation A** If I am in a coma or persistent vegetative state and have no known hope of recovering awareness or higher mental functions:			**Situation B** If I am in a coma and have a small but uncertain chance of regaining awareness and higher mental functioning:			**Situation C** If I am aware but have brain damage that makes me unable to recognize people, to speak meaningfully, or to live independently, and I have a terminal illness:		
	I want	I do not want	I want a trial; if no clear improvement, stop treatment.	I want	I do not want	I want a trial; if no clear improvement, stop treatment.	I want	I do not want	I want a trial; if no clear improvement, stop treatment.
1. Cardiopulmonary resuscitation. The use of pressure on the chest, drugs, electric shocks, and artificial breathing to revive me if my heart stops.			■			■			■
2. Mechanical respiration. Breathing by machine, through a tube in the throat.									
3. Artificial feeding. Giving food and water through a tube inserted either in a vein, down the nose, or through a hole in the stomach.									
4. Major surgery. For example, removing the gallbladder or part of the intestine.			■			■			■
5. Kidney dialysis. Cleaning the blood by machine or by fluid passed through the abdomen.									
6. Chemotherapy. Drugs to fight cancer.									
7. Minor surgery. For example, removing part of an infected toe.			■			■			■
8. Invasive diagnostic tests. For example, examining the stomach through a tube inserted down the throat.			■			■			■
9. Transfusions of blood or blood components.									
10. Antibiotics. Drugs to fight infection.									
11. Simple diagnostic tests. For example, blood tests or X rays.			■			■			■
12. Pain medications, even if they dull consciousness and indirectly shorten my life.			■			■			■

(over)

For each of the situations at right, check the boxes that indicate your wishes regarding treatment.	**Situation D** If I am aware but have brain damage that makes me unable to recognize people, to speak meaningfully, or to live independently, and I do not have a terminal illness:			**Situation E** If I have an incurable chronic illness that causes physical suffering or minor mental disability and will ultimately cause death, and then I develop a life-threatening but reversible illness:			**Situation F** If I am in my current state of health (describe briefly)_____ _____ _____ _____ and then develop a life-threatening but reversible disease:		
	I want	I do not want	I want a trial; if no clear improvement, stop treatment.	I want	I do not want	I want a trial; if no clear improvement, stop treatment.	I want	I do not want	I want a trial; if no clear improvement, stop treatment.
1. Cardiopulmonary resuscitation. The use of pressure on the chest, drugs, electric shocks, and artificial breathing to revive me if my heart stops.			■			■			■
2. Mechanical respiration. Breathing by machine, through a tube in the throat.									
3. Artificial feeding. Giving food and water through a tube inserted either in a vein, down the nose, or through a hole in the stomach.									
4. Major surgery. For example, removing the gallbladder or part of the intestine.			■			■			■
5. Kidney dialysis. Cleaning the blood by machine or by fluid passed through the abdomen.									
6. Chemotherapy. Drugs to fight cancer.									
7. Minor surgery. For example, removing part of an infected toe.			■			■			■
8. Invasive diagnostic tests. For example, examining the stomach through a tube inserted down the throat.			■			■			■
9. Transfusions of blood or blood components.									
10. Antibiotics. Drugs to fight infection.									
11. Simple diagnostic tests. For example, blood tests or X rays.			■			■			■
12. Pain medications, even if they dull consciousness and indirectly shorten my life.			■			■			■

Signed: _____

Signature Printed name

_____

Address Date

Witness: _____

Signature Printed name

_____

Address Date

Witness: _____

Signature Printed name

_____

Address Date

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