WELCOA

NEEDS & INTEREST SURVEY

1= NOT NEEDED 2=MIGHT BE NEEDED 3-ABSOLUTELY NEEDED

Please indicate the organizational need and personal need for each of the following programs if they were offered at work during the next year.	WORKPLACE NEEDS THIS			I NEED THIS		
	1	2	3	1	2	3
1. Educational Programs:						
a. Back Safety	☐	☐	☐	☐	☐	☐
b. Cancer Prevention	☐	☐	☐	☐	☐	☐
c. Heart Disease Prevention	☐	☐	☐	☐	☐	☐
d. Stroke Prevention Programs	☐	☐	☐	☐	☐	☐
e. Cholesterol Reduction	☐	☐	☐	☐	☐	☐
f. Home Safety	☐	☐	☐	☐	☐	☐
g. Substance Abuse	☐	☐	☐	☐	☐	☐
h. Headache Prevention & Treatment	☐	☐	☐	☐	☐	☐
i. Cold / Flu Prevention & Treatment	☐	☐	☐	☐	☐	☐
j. Ergonomics	☐	☐	☐	☐	☐	☐
k. Using Fitness Devices	☐	☐	☐	☐	☐	☐
l. Wellness and the Benefits Program	☐	☐	☐	☐	☐	☐
m. Weight Management	☐	☐	☐	☐	☐	☐
2. Employee Assistance Programs:						
a. Depression and Mental Health Screening/Treatment	☐	☐	☐	☐	☐	☐
b. Financial Management	☐	☐	☐	☐	☐	☐
c. Job Stress Management	☐	☐	☐	☐	☐	☐
d. Accepting Change	☐	☐	☐	☐	☐	☐
e. Parenting Successfully/Dependent Care	☐	☐	☐	☐	☐	☐
f. Managing Chronic Health Conditions (diabetes, hypertension, …)	☐	☐	☐	☐	☐	☐
g. Managing Chronic Pain (neck/shoulder injuries, back injuries, …)	☐	☐	☐	☐	☐	☐
h. Controlling Anger/Emotions	☐	☐	☐	☐	☐	☐
i. Work/Life Balance	☐	☐	☐	☐	☐	☐
j. Gratitude	☐	☐	☐	☐	☐	☐
k. Mindfulness	☐	☐	☐	☐	☐	☐
3. Physical Activity Programs:						
a. Corporate Physical Activity Membership Rates	☐	☐	☐	☐	☐	☐
b. Exercise Tolerance Testing (sub-maximal)	☐	☐	☐	☐	☐	☐
c. On-Site Exercise Equipment	☐	☐	☐	☐	☐	☐
d. Prescribed Exercise Programs	☐	☐	☐	☐	☐	☐
e. Stretching Programs	☐	☐	☐	☐	☐	☐
f. Walk-Fit Programs	☐	☐	☐	☐	☐	☐
g. Massage Therapy	☐	☐	☐	☐	☐	☐

RESET FORM

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	1	2	3	1	2	3
4. Immunization Programs:						
a. Flu Shots	☐	☐	☐	☐	☐	☐
b. Tetanus Shots	☐	☐	☐	☐	☐	☐
c. Lyme Disease Vaccine	☐	☐	☐	☐	☐	☐
d. Hepatitis 'B' Vaccine	☐	☐	☐	☐	☐	☐
e. TB Testing/Screening	☐	☐	☐	☐	☐	☐
f. Pneumonia	☐	☐	☐	☐	☐	☐
g. Shingles	☐	☐	☐	☐	☐	☐
5. Nutrition Education Programs:						
a. Healthy Cooking (meals/snacks)	☐	☐	☐	☐	☐	☐
b. Healthy Eating (do's & don'ts)	☐	☐	☐	☐	☐	☐
c. Weight Management Programs (diet & exercise)	☐	☐	☐	☐	☐	☐
d. Onsite Vending Machines with Healthy Choices	☐	☐	☐	☐	☐	☐
e. Healthy Meetings	☐	☐	☐	☐	☐	☐
f Disease Management Programs	☐	☐	☐	☐	☐	☐
6. Screening Programs:						
a. Blood Pressure Checks	☐	☐	☐	☐	☐	☐
b. Blood Sugar (diabetes)	☐	☐	☐	☐	☐	☐
c. Cholesterol Levels	☐	☐	☐	☐	☐	☐
d. Multiphasic Blood Screenings	☐	☐	☐	☐	☐	☐
e. Body Fat Testing	☐	☐	☐	☐	☐	☐
f. Cardiovascular (EKG's)	☐	☐	☐	☐	☐	☐
g. Colon / Rectal (cancer)	☐	☐	☐	☐	☐	☐
h. Prostate Checks (PSA)	☐	☐	☐	☐	☐	☐
i. Stool Checks (bowels)	☐	☐	☐	☐	☐	☐
j. Mammograms	☐	☐	☐	☐	☐	☐
k. Vision	☐	☐	☐	☐	☐	☐
l. Hearing Screening	☐	☐	☐	☐	☐	☐
m. A1C Testing	☐	☐	☐	☐	☐	☐
n. Waist Circumference	☐	☐	☐	☐	☐	☐
o. Body Mass Index	☐	☐	☐	☐	☐	☐
p. Bone Mineral Density	☐	☐	☐	☐	☐	☐
q. Other - Specify:	☐	☐	☐	☐	☐	☐

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	1	2	3	1	2	3
7. Tobacco Dependence/Smoking Cessation Programs	☐	☐	☐	☐	☐	☐
8. Asthma Program	☐	☐	☐	☐	☐	☐
9. Stress Reduction Programs	☐	☐	☐	☐	☐	☐
10. Priority Management Programs	☐	☐	☐	☐	☐	☐
11. Visiting On-site Healthcare Nurse	☐	☐	☐	☐	☐	☐
12. Self-Help / Self-Care	☐	☐	☐	☐	☐	☐

ANY OTHER INTEREST OR SUGGESTIONS (PLEASE SPECIFY) Please list any positive (or negative) comments regarding the impact of the current Wellness Program. Include how this program may have affected you personally. List any suggestions on how we can improve the current program or things you would like to see implemented. Your input is an IMPORTANT element to the success of our program.

RESET FORM