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A Review and Case Exemplifications of Health Enhancement Lifestyle Profile (HELP) and Its Screener (HELP–Screener) for Older Adults

Abstract

Growing interest in promoting healthy lifestyles as a way to enhance successful aging has led to the necessity of screening and monitoring lifestyle behaviors among older adults. The 56-item Health Enhancement Lifestyle Profile (HELP) and its screening version, the 15-item HELP-Screener are a set of instruments designed for assessing various health-related lifestyle behaviors in older adults, including exercise, diet, social and productive activities, leisure, activities of daily living, stress management and spiritual participation, and other health promotion and risk behaviors. This article depicts the critical features (e.g., administration and scoring) and clinical usefulness of the two instruments and reviews the literature that supports the instruments' psychometric properties (e.g., reliability and validity). Two case studies are also provided for exemplifying the clinical application of the tools. Occupational therapists can use the brief HELP-Screener for determining clients' need for further evaluation with the 56-item HELP wherein scrutiny of diverse lifestyle behaviors and consultation of possible health-promoting strategies can take place.

Comments

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Keywords

lifestyle assessment, health promotion, successful aging, health survey, psychometric properties

Credentials Display and Country

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The United States is experiencing considerable growth in its older population. According to the 2012 National Projections (Ortman, Velkoff, & Hogan, 2014), in 2050 the older population age ≥ 65 is projected to be 83.7 million, almost double the population of 43.1 million in 2012. This prediction indicates an immense need for increasing health-related services and education that would lead to better health and quality of life among older adults. In fact, the US is currently witnessing a paradigm shift in the nation's health-care focus from the treatment of disease to the prevention of disease, as well as to the promotion of healthy lifestyles (United States Department of Health and Human Services, Healthy People 2020, 2011). In the late 90's, Rowe and Kahn's *Successful Aging* (1997, 1998) provided an optimistic perspective on how older adults actively seek to live a lifestyle that prolongs their years and allows them to enjoy their old age. As supported by the findings of a series of studies sponsored by the MacArthur Foundation Research Network on Successful Aging (Rowe & Kahn, 1998), lifestyle choices play an important role in determining health and vitality among community-dwelling older adults. More recently, studies that carried on the framework of successful aging have also identified lifestyle as a modifiable factor that promotes health and prevents or delays the deteriorating effects of chronic illness among older adults (Adams, Leibbrandt, & Moon, 2011; Bowling & Iliffe, 2011; Bülow & Söderqvist, 2014; Meng & D'Arcy, 2014). As suggested by the results of these studies, a health-promoting lifestyle should embrace a holistic

paradigm that takes in physical, mental, and social behavioral approaches, such as a healthy diet, routine exercise, stress management, and social participation.

Occupational therapy has been known to adopt a holistic, client-centered approach in managing different lifestyle factors and occupations that can contribute to older adults' health and wellness (Clark et al., 2001; Clark et al., 1997; Clark et al., 2012; Hay et al., 2002; Mandel, Jackson, Zemke, Nelson, & Clark, 1999). Clark et al. (1997) stated in their landmark Well Elderly Study that "diet, lifestyle and daily routine, degree of social support, amount of exercise, and sense of autonomy and control play a strong positive role in enabling older individuals to maintain their health and independence" (p. 1321). Likewise, the overarching statement of the *Occupational Therapy Practice Framework: Domain and Process*, 3rd edition (hereinafter referred to as "the Framework"), "*achieving health, well-being, and participation in life through engagement in occupation*" (American Occupational Therapy Association [AOTA], 2014, p. S4), also suggests the role of occupational therapy in helping people shape their lifestyles through health-promoting occupations. The range of the lifestyle factors that reflect the essence of both the Successful Aging model (Rowe & Kahn, 1998) and the Well Elderly Study (Clark et al., 2001; Clark et al., 1997; Clark et al., 2012) are, in fact, deeply embedded in the domain and process of the Framework, such as activities of daily living, rest and sleep, work, leisure, social participation, habits and routines,

health promotion, and prevention. As professionals emphasizing the holistic care approach, occupational therapists must be aware of lifestyle choices in older adults and provide opportunities for enhanced levels of health and wellness.

Until recently, there has been a paucity of instruments developed to measure the various lifestyle factors in a holistic and systematic manner. Although abundant studies (e.g., the Well Elderly Study) have been conducted to determine the effectiveness of programs aimed at promoting healthy lifestyles among older adults, most of these studies focused on health outcome measures, such as physical functioning, health status, quality of life, or life satisfaction, yet failed to include a direct measure of the lifestyle factors or behaviors as a dimension of outcome evaluation. A comprehensive, systematic evaluation assessing the breadth of lifestyle behaviors is needed in order to reflect the nation's current health-care emphasis as well as the role of occupational therapy in services for older adults. To fill this gap, Hwang developed the Health Enhancement Lifestyle Profile (HELP) (Hwang 2010a, 2010b, 2010c) and its screening version, the HELP–Screener (Hwang, 2012a, 2012b, 2013). These are a set of self-report instruments designed for screening and monitoring health-related lifestyle factors and establishing the intervention plan and goals that aim to promote healthy lifestyles with aging.

Purpose

Through a synthesis of published research on the HELP and the HELP–Screener, this article reviews the critical features and psychometric

properties of the two instruments and provides case studies exemplifying their clinical application.

Health Enhancement Lifestyle Profile (HELP) Critical Features and Clinical Usefulness

The HELP is a self-report questionnaire to be administered to adults aged 55 years or older. It consists of two major sections. The first section consists of personal background and health information, such as age, gender, marital status, chronic disease or disabling conditions, and self-rated health. The second section of the HELP includes seven scales measuring different aspects of health-related lifestyle: (a) exercise, (b) diet, (c) social and productive activities, (d) leisure, (e) activities of daily living (ADLs/IADLs), (f) stress management and spiritual participation, and (7) other health promotion and risk behaviors (see Appendix for sample items). Each scale consists of eight items (questions) that examine the frequency of the respondent's engagement in various health-related activities or events. Individuals are asked to respond to each question according to their typical or routine performance during the past three-month period. Response categories generally include (a) never, (b) 1–2 days, (c) 3–4 days, (d) 5–6 days, (e) 7 days (per week), and (f) 1–2 days a month. For scoring, each response was given a numeric value reflective of the relative frequency, which results in a 0- to 5-point rating scale (Hwang, 2010a). Scores from negatively worded items are to be reversed. A subtotal score can be computed for each of the HELP scales, ranging from 0 to 40, where a higher score indicates a more favorable level of lifestyle. The normative descriptors (i.e., very unhealthy,

unhealthy, average, healthy, very healthy) for each of the seven HELP scales have been established using data (e.g., means, standard deviations) derived from multiple studies (Hwang, 2010a, 2010b, 2010c; Peralta-Catipon & Hwang, 2011) that yielded a normative (pooled) sample of 653 community-dwelling older adults. That is, each individual's subtotal score from each HELP scale can be converted to a descriptor indicative of a possible pattern of health-promoting or health-risk behaviors within that specific lifestyle domain.

The format of self-report adopted by the instrument enables the understanding of older adults' habits and routines in various health-promoting occupations, and, thus, yields client-centered lifestyle monitoring and/or recommendations. As described, the existing literature on successful aging and lifestyle factors, as well as the domain and terminology included in the Framework, contributed to the conceptualization and formation of the 56-item HELP (Hwang, 2010a). In particular, these sources rendered the structure of the multiple HELP scales that encompass the breadth of health-related lifestyle behaviors. These scales help identify an individual's relative strengths and limitations among those distinct areas of lifestyle (e.g., physical, mental, or social aspects). Accordingly, lifestyle interventions or recommendations can be tailored to each individual's specific needs. It is noteworthy that, rather than defining older adults by the cutoff age of 65+, the HELP extends its users to adults aged 55 years in an attempt to instill in these individuals the timely awareness and

recommendations of health-promoting lifestyles as they transition to late adulthood. Furthermore, the numeric rating scale (e.g., 1–2 days, 3–4 days, 5–6 days), unlike the commonly used Likert scale (i.e., never, sometimes, often), can yield a more objective measure suitable for intervention planning and goal setting as well as outcome evaluation (i.e., pre- and post-intervention comparison).

Evidence of Psychometric Properties

The preliminary content validity of the HELP was supported through two pilot testing procedures involving convenience samples of community-dwelling older adults: focus group and field pretesting (Hwang, 2010a). Both methods were aimed to enhance the relevance and clarity of the test items and to reflect better the perspectives of healthy lifestyle by older adults. The results from two pilot testing procedures, including participants' feedback and preliminary data, led to necessary revisions and modifications in different technical aspects of the HELP, such as question formation (e.g., separation of double-barrel questions), item wording, and response categories (Hwang, 2010a).

A sample of 257 older adults was recruited for a study that examined the internal validity of the HELP via the Rasch measurement model. Unidimensionality and data-model fit were largely supported for each of the seven HELP scales through the analyses of principal components of residuals, fit statistics, local independency, and differential item functioning (DIF) (Hwang, 2010a). The item hierarchy formed through logits provided an expected pattern of healthy lifestyle behaviors

for the HELP scales. Acceptable to good person separation and reliability statistics supported the clinical applicability and consistency of the HELP scores for measuring lifestyle behaviors among older adults. Finally, analysis of the rating scale structure confirmed the functioning of the 0- to 5-point rating scale used by the HELP. Overall, evidence of the internal validity of the HELP scales increases practitioners' confidence in using the instrument for intervention planning, monitoring, and outcome measurement of the targeted lifestyle behaviors. Although it is important to recognize the framework of healthy lifestyle as a whole, the subtotal score generated from each of the seven HELP scales can represent a conceptually distinct contributor to the healthy lifestyle (Hwang, 2010a). Accordingly, service planning can emphasize strategies to systematically facilitate or modify behaviors relevant to those specific lifestyle factors and behaviors concerning the individual.

Classic test theory was also used to examine validity and reliability of the HELP (Hwang, 2010b, 2010c). Construct validity was supported by the interrelationships found among the seven HELP scales and by the statistically significant correlations shown between the HELP results and global health status, including the self-related health and the number of chronic conditions; namely, the higher the HELP scores, the better the self-rated health and the lower the number of chronic conditions (Hwang, 2010b). Another study was conducted to determine convergent validity of the HELP (Hwang, 2010c). This study included a sample of 158 community-dwelling older adults

who were asked to complete both the HELP and the RAND-36 (Hays & Morales, 2001), a health-related quality of life (QoL) survey. Multiple regression revealed that five of the seven HELP scales (exercise, diet, ADLs, stress management and spiritual participation, and other health promotion and risk behaviors) served as significant predictors for the RAND-36 ($R^2 = 0.69$, $p < 0.0001$), indicating the potential contribution of healthy lifestyle behaviors to QoL for older adults (Hwang, 2010c). Finally, analysis of Cronbach's alpha, which examines the internal consistency of test items within a scale, yielded acceptable to good reliability coefficients (.75 to .92) across the HELP scales (Hwang, 2010b).

In summary, the HELP attempted to define lifestyle in a broader sense of the term to cover those physiological, psychological, social, and spiritual dimensions of health currently delineated in the literature of successful aging and occupational therapy. The psychometric properties confirmed through the multiple studies support that such an all-encompassing measure can hold the key to understanding the influences of various lifestyle factors on health, sense of well-being, and QoL among older adults.

Limitations

Several limitations of the HELP merit consideration by its users. First, the HELP is a self-report measure that requires each respondent to reflect on the frequency of his or her health-related lifestyle behaviors within the recent three months. An individual's levels of motivation, truthfulness, and cognitive capability (e.g., orientation, attention,

memory, comprehension) may affect the accuracy of the results (Hwang, 2010a). Second, given the dynamic, multifaceted nature of the lifestyle context, other critical factors, such as motivation, self-efficacy, functional status, and environmental supports or barriers, are not included in the HELP, and, thus, should be evaluated through other methods or instruments for more adequate problem identification and goal setting. Lastly, the HELP was developed and validated through multiple studies that included study samples consisting largely of community-dwelling older adults who resided in California. Cautions should be given when administering the HELP with other older adult populations.

Health Enhancement Lifestyle Profile–Screening Version (HELP–Screener) Critical Features and Clinical Usefulness

The HELP–Screener is a 15-item questionnaire that requires yes-or-no responses (Hwang, 2012a). Conceptually excerpted from its original version, the HELP–Screener also encompasses diverse aspects of health-related lifestyle behaviors, such as exercise, diet, socialization, leisure, and spirituality. All 15 questions are positively worded. Responses are coded as 1 (yes) or 0 (no), yielding a score range of 0–15; higher scores are indicative of healthier lifestyles. The time needed to complete the HELP–Screener is < 5 min. Some sample items are as follows:

- I exercise more than twice a week.
- I consume a variety of healthy foods rich in protein, fiber, or calcium every day (e.g.,

white meat, fish, fruits, vegetables, milk, soy products).

- I engage in activities in my community (e.g., attending senior center, volunteering) at least once a week.
- I frequently monitor my health (e.g., blood pressure, blood sugar, body weight).

To establish the cutoff criterion score for the HELP–Screener, a study using a quota sampling technique was conducted to recruit a sample of 494 older adults representative of diverse ethnic and socioeconomic groups in California (Hwang, 2012a). Data collected were tested for skewness and standard errors. The resultant Fisher skewness coefficient suggested that the distribution of data derived from the sample demonstrated a normal distribution. Therefore, one standard deviation below the mean of the HELP–Screener total scores from the study sample was used to form the cutoff score (i.e., 9) for the HELP–Screener (Hwang, 2012a).

The development of the HELP–Screener was launched through practitioners' demand (Hwang, 2012a). Since the dissemination of the HELP through conferences and publications, the instrument has been made available to occupational therapists and other practitioners on request. The author of the HELP constantly attended to users' comments on their experiences with the instrument. Many practitioners working with older adults in community settings expressed their interest in screening large numbers of clients for lifestyle behaviors in a more time-efficient manner. A plan to develop a brief form of the HELP was thus

proposed. The expectation was that such a brief and easy-to-score HELP–Screeners will be used by occupational therapy practitioners in their routine practice to screen for and identify older clients who may further benefit from an all-inclusive lifestyle evaluation or consultation. If a client’s score on the HELP–Screeners is < 9 , the established cutoff, the practitioner can then conduct the original 56-item HELP, leading to a more in-depth understanding of particular areas for intervention (Hwang, 2010a, 2012a). It is, however, noteworthy that the cutoff for the HELP–Screeners should be seen more as indicative rather than definitive (see Case Exemplification #2 for illustration). Practitioners can always exercise professional judgment in making clinical decisions after the screening.

Evidence of Psychometric Properties

To ensure the preliminary content validity of the HELP–Screeners, the questionnaire draft was pilot tested on a convenience sample of 32 community-dwelling older adults using one-on-one debriefing interviews (Hwang, 2012a). As a result, minor revisions were made to strengthen the questions’ semantic clarity. In general, the HELP–Screeners was considered easy to understand and time efficient.

Further psychometric properties of the HELP–Screeners were substantiated through the Rasch dichotomous model using data derived from the normative sample (Hwang, 2012a). First, principal components analysis of the standardized residuals confirmed the unidimensional construct of the HELP–Screeners; thus, the application of the 15-item questionnaire as a measure of the overall

lifestyle behavior is warranted. Second, goodness-of-fit statistics further supported the fit of the items to the Rasch model. Third, the correlation of standardized residuals between pairs of items largely supported the criterion of local independence (free of residual covariance) for the 15 items. Moreover, the DIF analysis corroborated the consistency of item calibration across gender, age, and ethnicity. Finally, the item hierarchy demonstrated through logits formed a sequential ordering of the HELP–Screeners items from least to most difficult with no indication of item overlap or gaps (Hwang, 2012a). All of these results consolidated the internal validity of the HELP–Screeners.

A study including a sample of 310 community-dwelling older adults examined concurrent validity and construct-related validity of the HELP–Screeners (Hwang, 2012b). Concurrent validity was supported through a high correlation ($r_s = .65$; $p < .0001$) between the scores of the HELP–Screeners and the original 56-item HELP. The construct-related validity was confirmed using the hypothesis-testing procedure. The first hypothesis was substantiated by a moderate negative correlation ($r_s = -.47$; $p < .0001$) between the test scores and the numbers of chronic illness reported by participants. The second hypothesis was validated by a moderate correlation ($r_s = .58$; $p < .0001$) between the test scores and self-ratings of health by participants. The 15-item HELP–Screeners is, to a certain extent, representative and predictive of the measure by the all-encompassing

56-item HELP, and is indicative of the overall health status of older adults.

The internal consistency of the HELP– Screener was analyzed using data derived from a sample of 483 older adults (Hwang, 2013). The resultant Cronbach’s α coefficient of .74 indicated an acceptable level of internal consistency. The test–retest reliability study using a 2-week interval with 90 participants yielded an intraclass correlation coefficient of .93, indicating a high degree of temporal stability of the instrument at the scale level. Moreover, good to excellent degrees of agreement found through the k statistic ($k_s = .76 - .96$) and percentage of agreement (96%–99%) between the test and retest scores of each item further supported the HELP–Screener’s test–retest reliability at the item level (Hwang, 2013). Such evidence of the consistency and stability of the test results is clinically important as it links to the purpose of the HELP–Screener for detecting habitual patterns of health-compromising behaviors among older adults.

In summary, conceptually akin to the multiple subscales included in the original HELP, the HELP–Screener defines healthy lifestyle as a broader term that encompasses the physical, dietary, psychological, social, spiritual, and occupational aspects of health-promoting behaviors. This instrument can serve as a quick, initial screen that would indicate whether further evaluation with the original 56-item HELP is necessary. Occupational therapy practitioners working with older adults in various clinical settings can benefit from using such

a short, wide-ranging lifestyle screening instrument as part of their routine evaluation of clients.

Limitations

Similar to the HELP, the HELP–Screener is a self-report instrument that necessitates the respondents’ recognition of the evaluation purpose along with their truthful response in order to secure useful and accurate results. For example, older adults with cognitive limitations, such as dementia, may need a proxy to complete the screener. To assist practitioners in decision making, other personal, environmental, and occupational (PEO) factors of the respondents must be incorporated into the screening process through other methods (e.g., interview, observation, chart review) or existing instruments, such as Occupational Performance History Interview-II (Kielhofner et al., 2004) or Interest Checklist (Heasman & Salhotra, 2008). Likewise, because an individual’s lifestyle can be affected by changes in his or her functional/health status and other PEO factors (e.g., personal budget, life/holiday events, community resources, weather), periodic re-administration of the HELP–Screener is needed to constantly monitor the individual’s lifestyle behaviors.

Case Exemplifications

The following are two simulated case studies that exemplify clinical application of both the HELP and the HELP–Screener.

Case #1

Margaret, 68 years of age, living with her husband in a senior apartment in an urban area, has diagnoses of rheumatoid arthritis, chronic back pain, hypertension, and hypercholesterolemia. She

participates twice a week in a community-based adult day care program. Margaret is aware of her sedentary lifestyle and irregular physical activity due to chronic pain; she frequently sits in her recliner watching TV or reading during the day when not attending the day care program. She complains of difficulty making homemade meals because of arthritic pain in her fingers and weakness in both hands. Margaret scores 8 out of 15 on the HELP– Screener. In light of Margaret's below cutoff score, the occupational therapist decides to administer the 56-item HELP to obtain a more in-depth understanding of particular areas of her lifestyle that warrant recommendations.

Margaret's scores in three of the HELP scales—exercise, diet, and ADLs/IADLs—fall into the normative descriptor of "unhealthy lifestyle". The therapist carefully reviews with Margaret the specific "unhealthy" behaviors indicated by the relevant items and scales in the HELP, such as low frequency of joint stretching, muscle strengthening, and aerobic exercises; over consumption of foods high in cholesterol, sodium, and saturated fat; insufficient intake of fruits, vegetables, and whole-grain foods; and low participation in food shopping and meal preparation. They both agree that the three deficit areas in her lifestyle are in fact intertwined by the issue surrounding physical pain and inactivity. Taking into account all of the PEO factors (e.g., interest, motivation, community sources, diagnostic attributes, functional capability, and limitation), the therapist and Margaret collaboratively establish the following goals:

- To set up a routine in which Margaret and her husband walk to a nearby supermarket and shop for ingredients to cook healthy homemade meals at least three times a week, instead of frequently driving to order meals at fast-food restaurants. (exercise, diet, ADLs/IADLs)
- To attend a free yoga class offered at the senior citizens center once a week. (exercise)
- To walk to the nearby weekend framers' market to purchase three to five favorite vegetables and fruits on weekends. (exercise, diet, ADLs/IADLs)

To assist in achieving Margaret's healthy lifestyle goals, the therapist prescribes wrist and hand home exercise programs and recommends a foldable grocery cart for shopping, adaptive tools for cooking (e.g., an electric can opener, grippers, rocker knives, lightweight cookware sets etc.), and some websites offering homemade food recipes and tips for dietary restrictions due to hypertension and hypercholesterolemia. Moreover, the therapist monitors and gives feedback on Margaret's lifestyle behaviors through the day care program's routine progress notes and re-administers the HELP during the semi-annual reassessment.

Case #2

Ronald, 70 years of age, a retired chemistry professor, living alone in a two-story house, has a long history of type 2 diabetes and recently suffered a mild stroke. His physician referred Ronald to the occupational therapist for functional and home safety evaluation. An initial occupational profile

interview reveals that Ronald has become indifferent to outings and socialization since his wife passed away last year. The results of functional assessments indicate no significant limitations in ADLs and IADLs post-stroke and Ronald further compliments himself on his ability to adhere to the healthy diet plan recommended by a diabetes specialist. Upon discussion, both Ronald and the therapist agree that his primary goal should focus on a holistic approach to health promotion and wellness.

Although Ronald scores 10 on the HELP– Screener (above the cutoff), he is found to exhibit a health-risk behavioral pattern pertaining to physical inactiveness as evidenced by three unendorsed items ("I exercise more than twice a week", "I engage in activities in my community at least once a week", and "I frequently avoid sedentary activities/behaviors"). Subsequently, the therapist decides to administer three pertinent HELP scales (exercise, social and productive activities, leisure) that offer an opportunity to observe a rich array of health-promoting behaviors favoring physical activeness. Alongside the results of the three HELP scales, Ronald's personal choices and goals for increasing the breadth and frequency of physical and social activities are determined:

- To walk outside with "Jimmy" (dog) for at least 20 min, three times a week. (exercise)
- To “rehabilitate” and care for Sophia's (wife) rose garden, 30-60 min, three times a week. (leisure)
- To “return” to the community golf club, once a week. (exercise, leisure)

- To visit Linda (daughter) and tutor two grandsons on weekends, 1-2 times a month. (social and productive activities)
- To go fishing with pals, 1-2 times a month. (leisure, social, and productive activities)

Given Ronald's initiative and motivation on his lifestyle modifications, the therapist instructs Ronald in self-administering and scoring the HELP every three months as a means of appraising and maintaining healthy lifestyle behaviors.

Conclusion

Particularly germane to the scope of occupational therapy practice is the promotion of health and wellness for all populations to optimize participation in daily occupations, namely, “Living Life To Its Fullest™” (AOTA, 2010). As lifetimes grow longer due to medical advances and the Baby Boomer generation in the United States ages, living life to its fullest will require prevention of health risks and maintenance of health-promoting behaviors to ensure a healthier lifestyle and greater quality of life in old age. To that end, assessing and monitoring lifestyle behaviors become essential roles of occupational therapists working with the older adult population. The 15-item HELP– Screener (Hwang, 2012a, 2012b; Hwang, 2013) and the 56-item HELP (Hwang, 2010b, 2010c, 2012c) were recently developed to fill the gap in lifestyle measurements. This article reviews the critical features, clinical usefulness, and psychometric properties of both instruments and provides two case studies exemplifying their clinical application.

The 15-item HELP–Screener is a reliable and valid tool designed to serve as a time-efficient

screen that determines if further evaluation with the original 56-item HELP is needed for a client. The further evaluation using the 56-item HELP can provide a more in-depth understanding of particular areas of the client's life warranting lifestyle modifications or regimens. Consequently, a variety of health-promoting occupations can be facilitated to provide opportunities for enhanced levels of health and wellness. Equally important, when engaging the client in collaborative treatment planning based on the results of the HELP tools, the

practitioner should also take into account the client's interests, routines, health and functional status, occupational history, and personal and environmental resources so as to yield a client-centered lifestyle intervention. In conclusion, both tools hold promise for appraising, cultivating, and maintaining healthy lifestyle behaviors that can forestall or delay the cascade of chronic illness and sustain an enduring sense of well-being in older adults.

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Appendix

Health Enhancement Lifestyle Profile (HELP) – Sample Items

Exercise

1. How often during a week do you walk outside or on a treadmill for at least 20 minutes as a form of exercise?
2. How often during a week do you perform stretching or flexibility exercises (such as joint mobility/stretching exercise, calisthenics or Yoga)?
3. How often during a week do you work out at the gym or at home (such as aerobic exercise or dance) for at least 20 minutes?

Diet

1. How often during a week do you eat three or more servings of healthy foods rich in protein in one day (such as white meat, lean poultry, fish, beans, nuts, reduced-fat milk, cottage cheese, tofu, or soymilk)?
2. How often during a week do you eat two or more servings of healthy foods rich in calcium in one day (such as milk products, yogurt, cheese, sardines or salmon, tofu, calcium-fortified orange juice, soymilk or cereals, spinach, collards, or calcium supplements)?
3. How often during a week do you eat three or more servings of fruits and vegetables in one day?

Social and Productive Activities

1. How often during a week do you visit or go out with your friends or family members or relatives who do not live with you?
2. How often during a week do you participate in a social, cultural, or support group that you belong to?
3. How often during a week do you go to volunteer work in the community?

Leisure

1. How often during a week do you read newspapers or favorite magazines, books, or novels?
2. How often during a week do you watch or listen to a favorite show/program on TV, radio station, or the Internet?
3. How often during a week do you go out for watching sport games, movies, concerts, plays, live shows, museums, or exhibitions?

ADL/IADL

1. How often during a week do you tend to ignore the routine for grooming and personal hygiene (such as combing, shaving, nail cutting, and teeth brushing/flossing)?
2. How often during a week do you tend to ignore the routine for bathing/showing or hair washing?
3. How often during a week do you stay up late at night or sleep less than five hours a night?

Stress Management and Spiritual Participation

1. How often during a week do you feel a sense of happiness and satisfaction in life due to the things you do throughout the day?
2. How often during a week do you spend at least 20 minutes in a day doing simple things that can bring about your good moods (such as caring for pets, or singing, reading, listening to music etc.)?
3. How often during a week do you talk with a special someone in the evening about how your day went?

Other Health Promotion and Risk Behavior

1. How often during a month do you drink three or more servings of alcohol-containing beverages in one day?
2. How often during a week do you smoke five or more cigarettes in one day?
3. How often during a month do you take pain medicine to control any form of body pain (such as migraine headache, arthritic pain, or back pain)?