Wellness Wheel Reflection: Reflect Before You Rate

Read each set of questions before choosing your Wellness Wheel numbers. You may circle a question, jot a note, or simply think about what is true for you. Your answers—not how you think you should be doing—will help you choose a rating on the next page.

Nourishment

Do I eat meals that nourish me and leave me satisfied? Am I often doing other things while eating, or can I slow down and pay attention to my food and hunger? How often do salty packaged foods, takeout, or caffeinated drinks fit into my day?

Movement

Do I move in ways I enjoy and can safely sustain? Do I break up long periods of sitting with a few minutes of movement? What helps or limits my ability to be active?

Rest & Sleep

Do I wake feeling rested? Do I need daytime naps—or wish I could take one? Has someone noticed snoring, gasping, or pauses in my breathing during sleep? If I use CPAP, how many hours do I use it each night?

Stress & Resilience

What causes stress in my day? Do I have stress-relief tools I can actually use, such as breathing, time outdoors, prayer, or asking for help? Do I have opportunities to recover?

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Wellness Wheel Reflection — continued

Use the space below each topic to jot down what you notice. These reflections can help you choose your Wellness Wheel ratings.

Connection

What is the overall quality of my relationships? Do they restore and support me, or leave me feeling drained? Do I have people I can turn to when I need support?

Environment

Does my home life and schedule support sleep, meals, movement, and rest? Are there barriers—time, money, caregiving, transportation, or safety—that make health habits difficult?

Purpose & Joy

Do I experience enjoyment in everyday life? Do I make time for creativity, self-expression, or play? Do I have faith in something bigger than myself, if that is meaningful to me? Do I connect with nature?

Health Habits & Accountability

Am I aware of my health needs and my blood pressure patterns? Have I set intentional, realistic wellness goals? Do I prioritize my health, notice my progress, and follow through on the steps I have chosen? What support would help?

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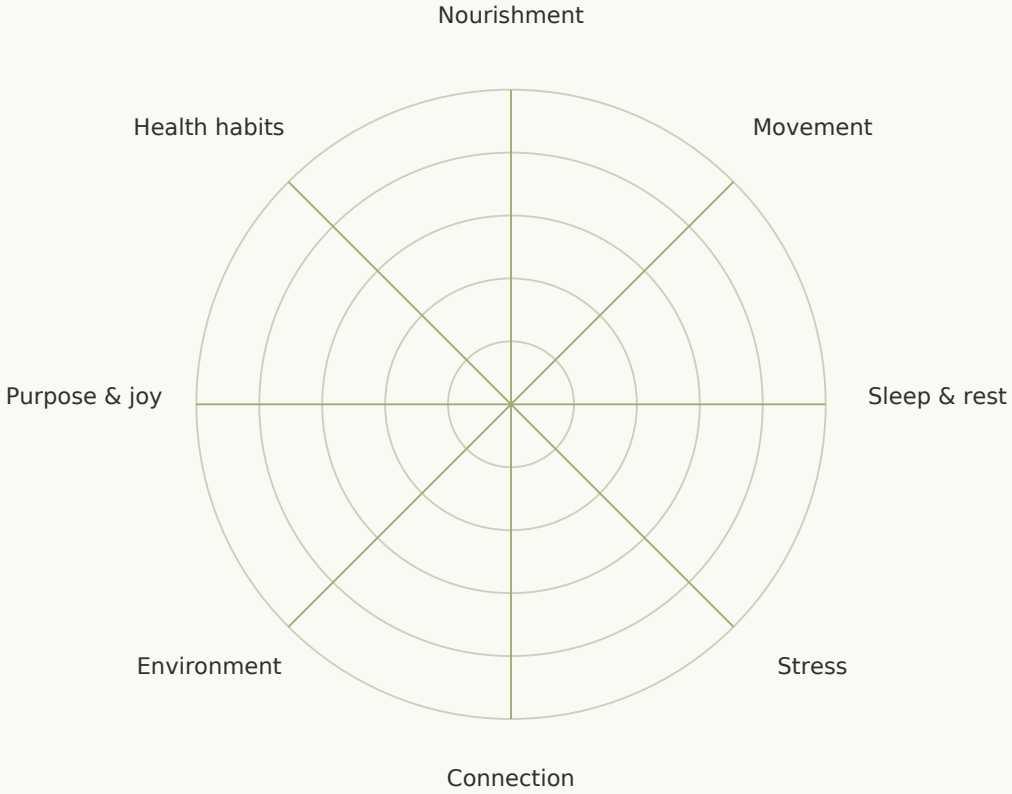
The Sacred Soil Wellness Wheel

Make a copy of this page before you fill it in. You can use it again to notice changes over time.

First: Read and answer the reflection prompts on the previous page. Then: rate how supported you feel in each area, from 1 to 10. Shade each spoke from the center outward and connect your marks. An uneven wheel may show where extra care could make life feel less bumpy.

Awareness, not blame

This is not a medical risk score. A low rating does not mean you caused hypertension, and a high rating does not rule it out. Your health is shaped by biology, circumstances, and access to support as well as habits.



Shade each spoke from 1 (center) to 10 (outer edge), then connect your marks.

Nourishment ___ Movement ___ Rest & Sleep ___ Stress & Resilience ___

Connection ___ Environment ___ Purpose & Joy ___ Health Habits ___

Print a fresh wheel in a few weeks or months to notice changes.

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A small-change plan

Your wheel is a starting point for curiosity. Choose one area that feels important and one change that fits your actual life. A small, steady step is more useful than a dramatic plan you cannot maintain.

One area I would like to nurture:

One specific, manageable action I will try this week:

What might get in the way? What support could help?

What I will notice or track:

Date I will revisit my wheel: _____

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Rest & Sleep: Look Beyond Hours

Sleep quality includes duration, continuity, and breathing. Someone may sleep for eight hours but still experience repeated breathing interruptions. A partner or loved one may notice signs that the sleeper does not remember.

Your sleep assessment

Typical hours of sleep per night: _____ Bedtime: _____ Wake time: _____

I wake feeling rested: ☐ Usually ☐ Sometimes ☐ Rarely

Someone has noticed loud or frequent snoring: ☐ Yes ☐ No ☐ Unsure

Someone has noticed pauses in breathing (apneic episodes—times when breathing stops briefly): ☐ Yes ☐ No ☐ Unsure

I wake gasping, choking, or snorting: ☐ Yes ☐ No ☐ Unsure

I experience morning headaches, dry mouth, or daytime sleepiness: ☐ Yes ☐ No ☐ Unsure

I have been diagnosed with sleep apnea: ☐ Yes ☐ No ☐ Unsure

If you use CPAP or another PAP device

Prescribed device: _____ Mask type: _____

I use it: ☐ Every night ☐ Most nights ☐ Some nights ☐ Rarely

Typical hours used per night: _____ Any discomfort or mask leaks? _____

My device report shows (if available): usage _____ leak _____ residual AHI _____

Residual AHI estimates breathing events per hour while using PAP; your sleep clinician should interpret it alongside symptoms, leaks, and the device report. Do not stop prescribed PAP therapy based on this worksheet.

When to seek evaluation

Witnessed breathing pauses, repeated gasping, or significant daytime sleepiness deserve medical discussion and may warrant a sleep study. Snoring alone does not diagnose sleep apnea, and sleep apnea can occur without obvious snoring.

*CPAP = continuous positive airway pressure, if prescribed. Write the hours you actually used it, not just hours spent in bed.

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Your Blood Pressure Log

Record two readings each session. Note symptoms or unusual circumstances. Copy this blank log for repeated use. Additional copies are available in the Sacred Soil Wellness Patient Handouts section.

Date / time	Reading 1	Reading 2	Pulse	Notes
	___ / ___	___ / ___		
	___ / ___	___ / ___		
	___ / ___	___ / ___		
	___ / ___	___ / ___		
	___ / ___	___ / ___		
	___ / ___	___ / ___		
	___ / ___	___ / ___		
	___ / ___	___ / ___		

Patterns I notice

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Weekly Lifestyle and Sleep Log

Use one row per day. Record what you can; blank spaces are okay. Copy this page for each new week or print another from the Patient Handouts section on the Sacred Soil Wellness website.

Week of: _____ Blood pressure goal discussed with clinician: _____

Day	Sleep hours	CPAP hours used*	Movement (minutes)	Stress 1–10
Mon				
Tue				
Wed				
Thu				
Fri				
Sat				
Sun				

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Nourishment, Fluids & Caffeine Log

Use the spaces below to note meals, salty/packaged foods, fluids, and caffeine. There is no need to count sodium unless your clinician recommends it. Follow any prescribed fluid or sodium restrictions.

Day	Meals / salty foods	Fluids (amount)	Caffeine (amount)
Mon			
Tue			
Wed			
Thu			
Fri			
Sat			
Sun			

spent in bed.

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Medication & Supplement Record

Bring this list to every appointment. Include prescriptions, over-the-counter medicines, herbs, vitamins, and supplements. Copy this page whenever you need a fresh record.

Name / purpose	Dose and timing	Prescribed by / reason	Questions or effects

Changes since my last visit:

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Preparing for Your Appointment

Appointment date: _____

Provider / clinician:

Typical morning reading:

Typical evening reading:

Highest recent reading:

Lowest recent reading:

Symptoms, concerns, or changes I have noticed:

Questions to ask—and room for answers

What is my personal blood pressure target?

How are my kidneys doing (eGFR, potassium, urine albumin)?

Could sleep apnea contribute to my readings? Should I have a sleep study or CPAP review?

What are the likely benefits and risks of my current treatment?

When should I check my blood pressure at home?

At what readings or symptoms should I contact your office?

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Medication Questions & Follow-Up

What does each medication do, and why is it right for me?

Which side effects need an urgent call?

What should I do if I miss a dose?

Are there interactions with my herbs, supplements, or other medicines?

Which blood or urine tests do I need, and how often should they be repeated?

What will we do at the next appointment, and how will we judge progress?

My follow-up plan

Next appointment (date/time): _____

What will happen at that appointment?

My next steps — check off as completed

☐ Schedule referral / specialist visit: _____

☐ Complete blood draw or urine testing: _____

☐ Pick up prescribed medication / supplies: _____

☐ Bring blood pressure log and CPAP report (if applicable)

☐ Other: _____

☐ Other: _____

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