Health Coaching Initial Intake and Pre-Assessment

Every Woman Matters
NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
4/2024

301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
www.dhhs.ne.gov/womenshealth

Reasonable accommodations made for persons with disabilities. TDD (800) 833-7352
Nebraska DHHS provides language assistance at no cost to limited English proficient persons who seek our services.

NOTES:

- **Who is this form for?** Women age 35-64 who are uninsured, under-insured and/or do not qualify for EWM.
- Please complete assessment form and submit to the Women's and Men's Health Program at the following email: dhhs.ewm@nebraska.gov or complete online by going to: https://www.surveymonkey.com/r/HCPreAssessment

Please answer each question and PRINT clearly!

CLIENT INFORMATION

Date Completed with Client: _____/_____/_____ Venue Name: _____
Assessment Completed: ❍In person ❍At-home/virtual
Community Health Hub (CHH):

❍Central District Health Department - CDHD
❍Elkhorn Logan Valley Public Health Department - ELVPHD
❍Lincoln Lancaster County Health Department - LLCHD
❍Panhandle Public Health Deaprtment - PPHD
❍South Heartland District Health Department - SHDHD
❍Southwest Nebraska Public Health Department - SWNPHD
❍Three Rivers Public Health Department - 3RPHD
❍Other _____

Client ID#: _____ ***(clients first 3 letters of last name and date of birth mmddyy; example CRA020564)***

Birthdate: _____/_____/_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Home Phone: (_____)_____ **Work Phone:** (_____)_____ **Cell Phone:** (_____)_____

Preferred way of Contact?: ❍Home Phone ❍Work Phone ❍Cell Phone ❍Email
Is it okay to text your cell phone? ❍Yes ❍No

Are you of **Hispanic/Latina(o) origin?** ❍Yes ❍No ❍Unknown

What is your **primary language** spoken in your home? ❍English ❍Spanish ❍Vietnamese ❍Other _____

What **race or ethnicity** are you? *(check all boxes that apply)*

❍American Indian/Alaska Native Tribe_____
❍Black/African American
❍Mexican American
❍White
❍Asian
❍Pacific Islander/Native Hawaiian
❍Other_____
❍Unknown

Are you a **Refugee?** ❍Yes ❍No ❍Unknown If yes, **where from**? _____

Highest level of **education** completed: ❍<9th grade ❍Some high school ❍High school graduate or equivalent ❍Some college or higher ❍Don't Know

County of Residence in Nebraska: _____

Do you have a **primary care physician**? ❍Yes ❍No ❍Unknown

Do you have **Health Insurance**? ❍Employer Coverage ❍Health Market ❍Medicare ❍Medicaid ❍No

DIET & PHYSICAL ACTIVITY

1. How many cups of **fruit** do you eat in an average day? *(1 cup equals 1 large banana or 1 medium apple)*	❍0 ❍1 ❍2 ❍3 ❍4 ❍5 ❍6+ ❍DK*
2. How many cups of **vegetables** do you eat in an average day? *(1 cup equals 12 baby carrots or 1 ear corn)*	❍0 ❍1 ❍2 ❍3 ❍4 ❍5 ❍6+ ❍DK*
3. Do you eat **fish** at least two times a week?	❍Yes ❍No ❍DK*
4. How many servings of **grain products** do you eat in a day? *(serving equals 1 slice whole wheat bread, 3 cups popped popcorn, 1/2 cup rice/pasta, 3/4 cup oatmeal)*	❍0 ❍1 ❍2 ❍3 ❍4 ❍5 ❍6+ ❍DK*
4a. Of these servings, how many are **whole grain?**	❍Less than half ❍About half ❍More than half ❍DK*
5. Do you drink less than 36 ounces of **beverages with added sugars** weekly? *(3 (12 ounce) cans regular soda, juice, alcohol, specialty drinks)*	❍Yes ❍No ❍DK*
6. Are you currently watching or reducing your **sodium** or **salt** intake?	❍Yes ❍No ❍DK*
7. How many minutes of **physical activity** do you get in a WEEK? *(walking/running, aerobic dancing, water aerobics, general gardening, bicycling)*	_____ Minutes ❍DK*

Continue to Page 2 ⇢ ⇢ ⇢

CHOLESTEROL, BLOOD PRESSURE & DIABETES

	HIGH BLOOD PRESSURE	HIGH CHOLESTEROL	DIABETES
1. Has your doctor, nurse or other health professional **EVER** told you that you have:	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*
2. Do you take any medication prescribed by your doctors **NOW** to lower:	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*	❍Yes ❍No ❍DK*
3. During the **past 7 days**, how many days *(including today)* did you take your medication as prescribed:	_____ Days ❍Not Applicable ❍DK*	_____ Days ❍Not Applicable ❍DK*	_____ Days ❍Not Applicable ❍DK*
4. On days you **did not take your medication** as prescribed, please tell us why:	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to take Meds ❍Other _____	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to take Meds ❍Other _____	❍Cost ❍Forgot to take ❍Side Effects ❍Need Refill ❍Don't Want to take Meds ❍Other _____
5. Do you check your **BLOOD PRESSURE** when you are not at the doctor's office *(at home, at pharmacy, or at a store, etc.)*?	❍Yes ❍No ❍DK*		
5a. If no, provide reason:	❍No, never told to check ❍No, don't know how to check ❍No, don't have equipment		
5b. If yes, how often do you check your **BLOOD PRESSURE**:	❍Multiple times a day ❍Daily ❍Weekly ❍A few times per week ❍Monthly ❍DK*		
5c. If yes, do you share your **BLOOD PRESSURE** numbers with your doctor that you take at home, the pharmacy or a store?	❍Yes ❍No ❍DK*		

HEART

1. Have you been **diagnosed** by a healthcare provider as having **any** of these conditions: ***(an answer is required for each)***	Coronary Heart Disease/Chest Pain:	❍Yes	❍No ❍Don't Know
	Congenital Heart Defects:	❍Yes	❍No ❍Don't Know
	Heart Failure:	❍Yes	❍No ❍Don't Know
	Stroke/Transient Ischemic Attack (TIA):	❍Yes	❍No ❍Don't Know
	Vascular Disease:	❍Yes	❍No ❍Don't Know
	Heart Attack:	❍Yes	❍No ❍Don't Know
	(females only) Gestational Hypertension:	❍Yes	❍No ❍Don't Know
	(females only) Gestational Diabetes:	❍Yes	❍No ❍Don't Know
	(females only) Pre-Eclampsia/Eclampsia:	❍Yes	❍No ❍Don't Know
2. Are you taking **aspirin daily** to help prevent a heart attack or stroke?		❍Yes	❍No ❍Don't Know

SMOKING

1. Do you **smoke**? Includes cigarettes, pipes, or cigars *(smoked tobacco in any form)*	❍Current Smoker ❍Quit (1-12 months ago) ❍Quit (More than 12 months) ❍Never Smoked

DAILY LIVING

1. Are you limited in any activities because of physical, mental or emotional problems?	❍Yes ❍No ❍DK*
2. Do **you now have** any health problems that requires you to use **special equipment**, such as a cane, a wheelchair, a special bed or a special telephone?	❍Yes ❍No ❍DK*
2a. If yes, what **type of disability**?	❍Emotional ❍Intellectual ❍Physical ❍Sensory
3. Over the past 2 weeks, **how often** have you been bothered by any of the following problems: 3a. **Little interest or pleasure in doing things**:	❍Not at all ❍Several days ❍More than half ❍Nearly every day
3b. **Feeling down, depressed, or hopeless**:	❍Not at all ❍Several days ❍More than half ❍Nearly every day

SOCIAL DETERMINANTS OF HEALTH

1. Do **you own or use** any of the following types of **computers**? 7a. Desktop/Laptop: 7b. Smartphone: 7c. Tablet/Other portable wireless computer:	❍Yes ❍No ❍DK* ❍Yes ❍No ❍DK* ❍Yes ❍No ❍DK*
2. Do you or any member of your household have **access to the internet**?	❍Yes-by paying a cell phone company / internet service provider ❍Yes-without paying a cell phone company / internet service provider ❍No access to internet in the house, apartment or mobile home ❍DK*
3. During the last **12 MONTHS**, was there a time when you were worried you would **run out of food** because of lack of money or other resources?	❍Yes ❍No ❍DK*
4. Have you ever **missed a doctor's appointment** because of **transportation** problems?	❍Yes ❍No ❍DK*
5. If you are currently using **child care services** please identify the type of services you use, if not, select *Not Applicable*. ***(select all that apply)***	❍Infant (Birth to 11 months) ❍Toddler (11 to 36 months) ❍Preschool (3 to 5 years) ❍After School Care (K-9th Grade) ❍Not Applicable ❍DK*
6. Have you had any of these **child-care related problems** during the past year? ***(select all that apply)***	❍Cost ❍Availability ❍Location ❍Transportation ❍Hours of Operation ❍Other ❍Not Applicable ❍DK*
7. What is your **housing situation**?	❍I have housing ❍I have housing, but I am worried about losing my housing ❍I do not have housing ❍DK*
8. The following will ask about **how safe you feel**:	
8a. How **often** does your partner **physically hurt you**?	❍Never ❍Rarely ❍Sometimes ❍Fairly Often ❍Frequently ❍Response not given
8b. How **often** does your partner **insult or talk down to you**?	❍Never ❍Rarely ❍Sometimes ❍Fairly Often ❍Frequently ❍Response not given
9. These four items are related to **medicine that you take** for ***any health conditions*** that you might have: 9a. Do you ever forget to take your medicine? 9b. Are you careless at times about taking your medicine? 9c. When you feel better, do you sometimes stop taking your medicine? 9d. Sometimes if you feel worse when you take your medicine, do you stop taking it?	❍Yes ❍No ❍Response not given ❍Yes ❍No ❍Response not given ❍Yes ❍No ❍Response not given ❍Yes ❍No ❍Response not given

SCREENING HISTORY

1. Have you had a mammogram in the last 2 years?
❍Yes ❍No ❍Don't Know

2. Have you had a Pap test in the last 3 years?
❍Yes ❍No ❍Don't Know

3. Have you been screened for colorectal cancer with a FIT/FOBT in the last year?
❍Yes ❍No ❍Don't Know

4. Have you been screened for colorectal cancer with a colonoscopy within the last 10 years?
❍Yes ❍No ❍Don't Know

**If client has answered no to any of the above questions, consider enrolling client into Women's and Men's Health Programs to receive screening services.*

BIOMETRICS

Date of Blood Pressure, Height, Weight: _____/____/____

BP 1: _____/_____ BP 2: _____/_____

Height: _____ Weight: _____

Waist Circumference: _____

Client fasted 9 hours: ❍Yes ❍No

Total Cholesterol: _____

HDL: _____ LDL: _____ Glucose: _____

Cholesterol test:
❍Not Applicable ❍Refused
❍Performed by Health Coach ❍Self Reported
❍Performed by Healthcare Provider

Date of Total Cholesterol: _____/_____/_____