

Health Coaching wPre/Follow Up Assessment

CLIENT INFORMATION**YOUR INFORMATION**

First Name: _____ Last Name _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - ____ Cell Phone: (____) _____ - ____

Email address: _____

Date of Birth: ____/____/____ Gender: Male Female Hispanic: Yes NoRace (check all that apply): White Black Mexican Asian Native American Pacific Islander Other _____**Are you limited in any way in any activities because of physical, mental or emotional problems?** Yes No Don't Know Don't want to answer**Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?** Yes No Don't Know Don't want to answer

If yes, what type of disability?

Are you a Refugee? Yes No Unknown

If yes, where from? _____

County of Residence in Nebraska: _____

Preferred Counties in Nebraska: _____

Do you have a primary care physician? Yes No**Do you have Health Insurance?** Employer Coverage Health Market Medicare
 Medicaid No**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 ago) Never Smoked**Has your doctor, nurse, or other health professional EVER told you that you have high blood pressure?** Yes No NA**Do you take any medication prescribed by your doctors NOW to lower high blood pressure?** Yes No Don't Know NA**During the past 7 days, how many days (including today) did you take your blood pressure medicine?** 1 2 3 4 5 6 7 DK**Has your doctor, nurse or other health professional EVER told you that you have diabetes?** Yes No NA**Do you take any medication prescribed by your doctors NOW to lower diabetes (blood sugar)?** Yes No Don't Know NA**During the past 7 days, how many days (including today) did you take your diabetes medicine?** 1 2 3 4 5 6 7 DK**Has your doctor, nurse or other health professional EVER told you that you have high cholesterol?** Yes No NA**Do you take any medication prescribed by your doctors NOW to lower high cholesterol?** Yes No Don't Know NA**During the past 7 days, how many days (including today) did you take your cholesterol medicine?** 1 2 3 4 5 6 7 DK

Have you been diagnosed by a healthcare provider as having Coronary Heart Disease/Chest Pain?

Yes No Don't Know

Have you been diagnosed by a healthcare provider as having Congenital Heart Defects?

Yes No Don't Know

Have you been diagnosed by a healthcare provider as having Heart Failure?

Yes No Don't Know

Have you been diagnosed by a healthcare provider as having Stroke/Transient Ischemic Attack (TIA)?

Yes No Don't Know

Have you been diagnosed by a healthcare provider as having Vascular Disease?

Yes No Don't Know

Have you been diagnosed by a healthcare provider as having a Heart Attack?

Yes No Don't Know

Are you taking aspirin daily to help prevent a Heart Attack or Stroke?

Yes No Don't Know

Have you had a mammogram in the last 2 years?

Yes No Don't Know

Have you had a pap test in the last 3 years?

Yes No Don't Know

Have you been screened for colorectal cancer?

Yes No Don't Know

Pre and Follow up Assessment

Do you eat Fish at least two times a week?

Yes No Don't Know

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 Don't Know

Are you currently watching or reducing your sodium or salt intake?

Yes No Don't Know

How much 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 or more

Don't Know

How many 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 or more

Don't Know

Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?

Not at all Several days More than half Nearly every day

Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

Not at all Several days More than half Nearly every day

How many servings of grain products do you eat in a day?

(serving equals 1 slice of whole wheat bread, 3 cups of popped popcorn, ½ cup rice/pasta, ¾ cup oatmeal)

1 2 3 4 5 6 Don't Know

Of your daily servings of grain how many of these servings are whole grains?

Less than half About half More than half

Don't Know

How many minutes of physical activity do you get in a WEEK? (walking/running, aerobic dancing, water

aerobics, general gardening, bicycling)

0 30 min 60 min 75 min or more

Don't Know

_____/_____/_____ Blood Pressure 1

_____/_____/_____ Blood Pressure 2

_____ Height

_____ Weight

_____ Waist Circumference

_____ Total Cholesterol

_____/_____/_____ Date of Total Cholesterol