Please answer the following questions and return it in the envelope provided within 1-2 weeks. This will help us create better programs for women in Nebraska!

You can take this survey online if you prefer by going to this link: https://www.surveymonkey.com/r/EWMAssessment

Thanks! -EWM Staff

FOR HEALTH COACHES USE ONLY
Client ID#: _____
Client County: _____
Date of Service: ____/____/____
Date of Call: ____/____/____
Name of CHH: _____
_____

DIET & PHYSICAL ACTIVITY	
1. How much **fruit** do you eat in an average day? *(1 cup equals 1 large banana or 1 medium apple)*	_____ Cups ❍DK*
2. How many **vegetables** do you eat in an average day? *(1 cup equals 12 baby carrots or 1 ear corn)*	_____ Cups ❍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)*	❍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*

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 ❍DK*	_____ Days ❍DK*	_____ Days ❍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*		

*DK - Don't Know/Not Sure

HEART	1. Have you been **diagnosed** by a healthcare provider as having **any** of these conditions: *(mark all that apply)*	
	Coronary Heart Disease/Chest Pain:	❍Yes ❍No ❍DK*
	Congenital Heart Defects:	❍Yes ❍No ❍DK*
	Heart Failure:	❍Yes ❍No ❍DK*
	Stroke/Transient Ischemic Attack (TIA):	❍Yes ❍No ❍DK*
	Vascular Disease:	❍Yes ❍No ❍DK*
	Heart Attack:	❍Yes ❍No ❍DK*
	2. Are you taking **aspirin daily** to help prevent a heart attack or stroke?	❍Yes ❍No ❍DK*

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 LIFE	1. Thinking about your **physical health**, which includes physical illness and injury, on how many days during the past **30 days** was your physical health **not good**?	_____ Days ❍DK*
	2. Thinking about your **mental health**, which includes stress, depression, and problems with emotions, on how many days during the past **30 days** was your mental health **not good**?	_____ Days ❍DK*
	3. During the past **30 days**, on about how many days did poor physical or mental health keep you from doing your **usual activities**, such as self-care, work, or recreation?	_____ Days ❍DK*
	4. Are you limited in any activities because of physical, mental or emotional problems?	❍Yes ❍No ❍DK*
	5. 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*
	5a. If yes, what **type of disability**?	❍Emotional ❍Intellectual ❍Physical ❍Sensory
	6. Over the past 2 weeks, **how often** have you been bothered by any of the following problems: 6a. **Little interest or pleasure in doing things**:	❍Not at all ❍Several days ❍More than half ❍Nearly every day
	6b. **Feeling down, depressed, or hopeless**:	❍Not at all ❍Several days ❍More than half ❍Nearly every day

**DK - Don't Know/Not Sure*

REQUIRED: FOR HEALTH COACHES USE ONLY

Height (inches): _____ Weight (pounds): _____
Waist Circumference (inches): _____

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

Client fasted 9 hrs: ❑Yes ❑No
Total Cholesterol**: _____
***If TC is >240 WW **REQUIRES** an additional cholesterol test.*
HDL:_____ Triglycerides: _____ LDL: _____
Non-HDL: _____ TC/HDL: _____

Cholesterol test performed by:
❑Primary Care Provider
❑Local Health Department by Cholestech Machine
❑Other _____

What Healthy Behavior Support Services did you participate in?
❑National Diabetes Prevention Program (NDPP) ❑Living Well
❑Check. Change. Control. ❑Walk & Talk Toolkit
❑Health Coaching ❑Other _____

EWM would like to share test results with a preferred physician.
What is the name/address/phone number of preferred physician:
Physician Name: _____
Address: _____
Phone Number: (_____)_____

Nebraska Colon Cancer Screening Program

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Every Woman Matters
Nebraska Office of Women's Health

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