Health Coaching Post-Assessment

Every Woman Matters
NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES
11/2023

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Lincoln, NE 68509-4817 Fax: 402-471-0913
1-800-532-2227
www.dhhs.ne.gov/womenshealth

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/HCPostAssessment
- Post Biometrics are REQUIRED. If previous cholesterol was ≥240 mg/dl, a total cholesterol is REQUIRED.

Please answer each question and PRINT clearly!

CLIENT INFORMATION

Date Completed with Client: _____/_____/_____

Community Health Hub (CHH):

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

Client ID#: _____ **MedIt ID#:** _____

Birthdate: _____/_____/_____

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)*	❍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*

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. 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*		
4a. If no, provide reason:	❍No, never told to check ❍No, don't know how to check ❍No, don't have equipment		
4b. If yes, how often do you check your **BLOOD PRESSURE**:	❍Multiple times a day ❍Daily ❍Weekly ❍A few times per week ❍Monthly ❍DK*		
4c. 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*		

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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
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

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 ❍Physical	❍Intellectual ❍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 ❍More than half	❍Several days ❍Nearly every day
3b. **Feeling down, depressed, or hopeless**:	❍Not at all ❍More than half	❍Several days ❍Nearly every day

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: _____/_____/_____