Health Coaching Initial Intake and Pre-Assessment

11/2023

Every Woman Matters

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

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

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:** ________________________________

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#: ______________________ *(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______________________
- ❍ Mexican American
- ❍ Asian
- ❍ Other______________________________
- ❍ Black/African American
- ❍ White
- ❍ Pacific Islander/Native Hawaiian
- ❍ 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 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*

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 ❍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*		

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

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

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
❍Performed by Health Coach
❍Performed by Healthcare Provider
❍Refused
❍Self Reported

Date of Total Cholesterol: _______/_______/_______