Client Identification

Program # ___ ___ ___ Last Name ______________________________ First Name ______________________________ MI _____
Please PRINT *Please PRINT*

ID # ___ ___ ___ ___ ___ ___ ___ ___ ___

Evaluation Date generating contact: ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*
(*Enter Visit Date from* ***Evaluation form***)

Risk Reduction / Readiness to Change / Priority Areas

1. Type of Contact: ⬭ 1. Face to Face ⬭ 2. Telephone

2. Risk factors with screening values communicated (risk reduction counseling):
   a. Verbally ⬭ 1. Yes ⬭ 2. No
   b. Written ⬭ 1. Yes ⬭ 2. No

3. Risk reduction **counseling date** ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

4. Risk reduction **counseling completion date** ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

5. Readiness to change **assessment date** ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

6. Participant **stage of change** ⬭ 1. Pre-contemplation ⬭ 2. Contemplation ⬭ 3. Preparation ⬭ 4. Action ⬭ 5. Maintenance

7. Did the client accept health coaching? ⬭ 1. Yes ⬭ 2. No

8. Participant decided the following are **priority areas**:
   a. Nutrition ⬭ 1. Yes ⬭ 2. No
   b. Physical activity ⬭ 1. Yes ⬭ 2. No
   c. Smoking cessation ⬭ 1. Yes ⬭ 2. No
   d. Medication adherence for hypertension (high blood pressure) ⬭ 1. Yes ⬭ 2. No
   e. Mental health ⬭ 1. Yes ⬭ 2. No

9. Counseling related to heart disease risk provided about:
   a. Nutrition ⬭ 1. Yes ⬭ 2. No
   b. Physical activity ⬭ 1. Yes ⬭ 2. No
   c. Smoking Cessation ⬭ 1. Yes ⬭ 2. No
   d. Mental Health ⬭ 1. Yes ⬭ 2. No

10. During this contact, participant referred to community-based resources related to:
   a. Nutrition
      i. Dietitian services ⬭ 1. Yes ⬭ 2. No
      ii. Chronic Disease Self-Management Program (CDSMP) ⬭ 1. Yes ⬭ 2. No
      iii. Fresh Conversations ⬭ 1. Yes ⬭ 2. No
      iv. Other Nutrition ⬭ 1. Yes ⬭ 2. No
   b. Physical activity
      i. YMCA ⬭ 1. Yes ⬭ 2. No
      ii. Other Physical Activity ⬭ 1. Yes ⬭ 2. No
   c. Other: ___________________________

11. Community-based resources follow up—participant participated in the following:
   a. Nutrition
      i. Dietitian services ⬭ 1. Yes ⬭ 2. No
      ii. Chronic Disease Self-Management Program (CDSMP) ⬭ 1. Yes ⬭ 2. No
      iii. Fresh Conversations ⬭ 1. Yes ⬭ 2. No
      iv. Other Nutrition ⬭ 1. Yes ⬭ 2. No
   b. Physical activity
      i. YMCA ⬭ 1. Yes ⬭ 2. No
      ii. Other Physical Activity ⬭ 1. Yes ⬭ 2. No

Tobacco Cessation (Quitline)

12. Date of referral to tobacco cessation resource ___ ___ / ___ ___ / ___ ___ ___ ___ *(mm / dd / yyyy)*

13. Type of tobacco cessation resource: ⬭ 1. Quit line ⬭ 2. Community-based tobacco program ⬭ 3. Other tobacco cessation resource

14. Tobacco cessation activity completed
   ⬭ 1. Yes—Completed tobacco cessation activity
   ⬭ 2. No—Partially completed tobacco cessation activity
   ⬭ 3. No—Refused tobacco cessation activity when reached
   ⬭ 4. No—Could not reach to conduct tobacco cessation activity

Program Staff Initials: ___ ___ ___