Client Identification

Program # __ __ __ Last name _____ Assessment Date __ __ / __ __ / __ __ __ __

ID # __ __ __ __ __ __ __ __ __ First Name_____ Middle Initial _____

Con't.Client Medical History

4. Have you had any of the following:

a. Stroke/TIA?
- ◯ 1. Yes
- ◯ 2. No
- ◯ 3. Don't know/Not sure

b. Heart attack?
- ◯ 1. Yes
- ◯ 2. No
- ◯ 3. Don't know/Not sure

c. Coronary heart disease?
- ◯ 1. Yes
- ◯ 2. No
- ◯ 3. Don't know/Not sure

d. Heart failure?
- ◯ 1. Yes
- ◯ 2. No
- ◯ 3. Don't know/Not sure

e. Vascular disease (peripheral arterial disease)?
- ◯ 1. Yes
- ◯ 2. No
- ◯ 3. Don't know/Not sure

f. Congenital heart disease and defects?
- ◯ 1. Yes
- ◯ 2. No
- ◯ 3. Don't know/Not sure

5. Are you taking aspirin daily to help prevent a heart attack or stroke?
- ◯ 1. Yes
- ◯ 2. No
- ◯ 3. Don't know/Not sure

Client Diet and Physical Activity

6. How many cups of fruits and vegetables do you eat in an average day?
__ __Cups

7. Do you eat fish at least two times a week?
- ◯ 1. Yes
- ◯ 2. No

8. Thinking about all the servings of grain products you eat in a typical day, how many are whole grains?
- ◯ 1. Less than half
- ◯ 2. About half
- ◯ 3. More than half

9. Do you drink less than 36 ounces (450 calories) of sugar sweetened beverages weekly?
- ◯ 1. Yes
- ◯ 2. No

10. Are you currently watching or reducing your sodium or salt intake?
- ◯ 1. Yes
- ◯ 2. No

11. Do you eat 1,500 mg or less of sodium or salt daily?
- ◯ 1. Yes
- ◯ 2. No

12. In the past 7 days, how often did you have a drink containing alcohol?
__ Days

13. How many alcoholic drinks, on average, do you consume during a day you drink?
__ __ Number of drinks

14. How many minutes of physical activity (exercise) do you get in a week?
__ __ __ __ Minutes

Client Quality of Life

15. Over the past 2 weeks, how often have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things?
- ◯ 1. Not at all
- ◯ 2. Several days
- ◯ 3. More than half
- ◯ 4. Nearly every day

b. Feeling down, depressed, or hopeless?
- ◯ 1. Not at all
- ◯ 2. Several days
- ◯ 3. More than half
- ◯ 4. Nearly every day

16. How confident are you that you can manage and control most of your health problems?
- ◯ 1. Very confident
- ◯ 2. Somewhat confident
- ◯ 3. Not confident
- ◯ 4. I don't have any health problems