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| **DEPARTMENT OF HEALTH SERVICES**  Division of Public Health  F-01225 (09/2024) | | | **STATE OF WISCONSIN**  Bureau of Community Health Promotion  Chronic Disease Prevention and Cancer Control Section | | | |
| wisewoman Healthy Behavior Encounter | | | | | | |
| **SECTION 1 – CLIENT AND PROVIDER INFORMATION** | | | | | | |
| 1. Provider Agency Name | | | | 2. Performing Provider Name | | |
|  | | | |  | | |
| 3. Client MED-IT Number | | 4. Date of Contact | | | | 5. Date of the IOV |
|  | |  | | | |  |
| 6. Client Name (Last, First MI) | | | | 7. Date of Birth | | |
|  | | | |  | | |
| 8. Preferred Contact Option(s) (select all that apply) | | | | | | |
| Phone | Main Phone Number: | | | | Alternate Phone Number: | |
| Text | Cell Phone Number: | | | | | |
| Email | Email Address: | | | | | |
| Best Time to Contact | | | | | | |
|  | | | | | | |
| **SECTION 2 – INITIAL HEALTHY BEHAVIOR SUPPORT ENCOUNTER Date:** | | | | | | |
| 9. Client Selected a HBSS:  Yes – (Name)        No – 30 Day Call Back | | | | | | |
| 10. Client Priority Area (select all that apply) | | | | | | |
| Healthy Eating  Physical Activity  Blood Pressure Control  Quit Smoking  Weight Loss | | | | | | |
| 11. Indicate SMART Goal: | | | | | | |
| 12. Community Referrals (select all that apply) | | | | 13. Social Services and Support Referrals (select all that apply) | | |
| Healthy Eating  Physical Activity  Blood Pressure Control  Quit Smoking  Weight Loss  Other(s) – Specify: | | | | Food Security  Housing  Transportation  Childcare  Home Safety  Medication Assistance  Other(s) – Specify: | | |
| SECTION 3 – SUBSEQUENT HEALTH COACHING ENCOUNTERS | | | | | | |
| *Complete if client had general coaching.* **Date:** | | | | | | |
| 14. Did the client achieve the stated goal(s)? | | | | | | |
| Yes – Client Achieved Goal (select all that apply)  Eating Healthier  Increased Physical Activity  Lower/Controlled Blood Pressure  Stopped Smoking  Lost Weight | | | | No – Barriers/Challenges (select all that apply)  Time  Motivation  Competing Priorities | | |
| 15. Did the client make progress on the stated goal(s)? | | | | | | |
| Yes – Made Progress on Stated Goal(s) (select all that apply)  Eating Healthier  Increased Physical Activity  Lower/Controlled Blood Pressure  Stopped Smoking  Lost Weight | | | | No – Barriers/Challenges (select all that apply)  Time  Motivation  Competing Priorities | | |
| 16. Were additional Social Services & Support Referrals offered?  Yes – Specify:        No | | | | | | |
| Summary of Session Notes (*education tools provided and next session date/time*) | | | | | | |
| SECTION 4 – BLOOD PRESSURE SELF-MONITORING HEALTH COACHING | | | | | | |
| *Complete if client had Blood Pressure Self-Monitoring coaching.* **Date:** | | | | | | |
| 17. Agreed Provider/Client BP Goal:      / | | | | Calculated Average SMBP Reading:      / | | |
| 18. Did the client achieve blood pressure goal? | | | | | | |
| Yes (select all that apply)  Able to Get Medications  Taking BP Medications Correctly  Lowered Sodium  Doing BPSM  Readings Shared with Provider  Lost Weight  Increased Physical Activity  Stopped Smoking | | | | No – Barriers/Challenges (select all that apply)  Time  Motivation  Competing Priorities | | |
| 19. Did the client make progress on blood pressure goal? | | | | | | |
| Yes (select all that apply)  Able to Get Medications  Taking BP Medications Correctly  Lowered Sodium  Doing BPSM  Readings Shared with Provider  Lost Weight  Increased Physical Activity  Stopped Smoking | | | | No – Barriers/Challenges (select all that apply)  Time  Motivation  Competing Priorities | | |
| 20. Were additional Social Services & Support Referrals offered?  Yes – Specify:        No | | | | | | |
| Summary of Session Notes (*education tools provided and next session date/time*) | | | | | | |
| SECTION 5 – WALK WITH EASE HEALTH COACHING | | | | | | |
| *Complete if client had Walk with Ease health coaching.* Date: | | | | | | |
| Target Walking Time Goal: | | | | | | |
| 21. Did client achieve target walking time goal? | | | | | | |
| Yes – Number of Minutes: | | | | No – Barriers (select all that apply)  Time  Motivation  Competing Priorities | | |
| 22. Did client make progress on target walking time goal? | | | | | | |
| Yes – Number of Minutes: | | | | No – Barriers (select all that apply)  Time  Motivation  Competing Priorities | | |
| 23. Were additional Social Services & Support Referrals offered?  Yes – Specify:        No | | | | | | |
| Summary of Session Notes *(education tools provided and next session date/time)* | | | | | | |
| **Note:** Unsuccessful attempt(s) should be recorded in the Med-IT Recall screen. Examples include, no answer, wrong number, number disconnected, and unable to talk. | | | | | | |