

Health Coaching Evaluation Form

Client's Name: _____

Client's ID#: _____

Client's phone number: _____

Coach's Name: _____

Client's email: _____

Session 1 (1 week)

Was the session completed? Yes No

Date when session was completed: ____/____/____

Time when session was completed: ____:____ am or pm

Enter date/time of prior attempts:

	Date	Time
1 st		
2 nd		
3 rd		

Male Female

Age: <5 5-17 18-59 60+

Are you Hispanic/Latino? Yes No

(Includes Mexican, Cuban, Puerto Rican, Central and South American, or other Spanish culture or origin regardless of race.)

Race: Check all that apply

American Indian or Alaska Native

Native Hawaiian or other Pacific Islander

Asian

White

Black or African American

How many people are currently living or staying with you at your house? _____

Ask behavior questions:

1. How often do you eat food from each food group every day? (Food groups include dairy, grains, fruits, vegetables, and protein)

Never Seldom Sometimes Most Times Always

2. During the past week, how many cups of fruit did you eat on an average day?

Cups: None 1/2 1 1 1/2 2 2 1/2 3 3 1/2 or more

3. How often do you eat more than one kind of fruit each day?

Never Seldom Sometimes Most Times Always

4. During the past week, how many cups of vegetables did you eat on an average day?

Cups: None 1/2 1 1 1/2 2 2 1/2 3 3 1/2 or more

5. How often do you eat more than one kind of vegetable each day?

Never Seldom Sometimes Most Times Always

6. When you drink milk, how often do you choose:

Whole milk (full fat) or reduced fat (2%) milk

Low-fat (1%) milk or fat-free (skim) milk

(including soy or almond milk)

	Never	Seldom	Some-times	Most Times	Always	Do Not drink milk
Whole milk (full fat) or reduced fat (2%) milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low-fat (1%) milk or fat-free (skim) milk (including soy or almond milk)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. When you eat yogurt, how often do you choose:

Whole milk yogurt

Low-fat or nonfat yogurt

	Never	Seldom	Some-times	Most Times	Always	Do Not eat yogurt
Whole milk yogurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low-fat or nonfat yogurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Coaching Evaluation Form

8. When you eat rice, how often do you choose:

- Brown rice
- White rice

Never	Seldom	Some-times	Most Times	Always	Do Not eat rice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. When you eat pasta, how often do you choose:

- Whole grain/wheat pasta
- Regular pasta

Never	Seldom	Some-times	Most Times	Always	Do Not eat pasta
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. When you eat bread or tortillas, how often do you choose:

- Whole grain/wheat bread or tortillas
- White bread or flour tortillas

Never	Seldom	Some-times	Most Times	Always	Do Not eat bread/tortillas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. When you eat cereal, how often do you choose:

- Whole grain cereals (toasted oats, bran, granola, oatmeal)
- Refined grain cereals (corn flakes, puffed rice)

Never	Seldom	Some-times	Most Times	Always	Do Not eat cereal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. When you eat chicken or turkey, how often do you choose:

- Skinless chicken or turkey
- Chicken or turkey with skin

Never	Seldom	Some-times	Most Times	Always	Do Not eat chicken/turkey
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. When you eat ground beef, how often do you choose:

- 90% lean or greater
- 85% or 80% lean or less

Never	Seldom	Some-times	Most Times	Always	Do Not eat ground beef
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How often do you eat sausage, bacon, or hot dogs?

- Never Seldom Sometimes Most Times Always

15. During the past week, how many 1 cup servings of sugar-sweetened beverages did you drink on an average day? (1 cup serving = 8 ounces)

- Cups: None 1 2 3 4 5 or more

16. How often do you eat low-sodium options when eating packaged foods such as canned soups or vegetables, pre-packaged rice, frozen meals, etc.?

- Never Seldom Sometimes Most Times Always

17. How many minutes of physical activity do you get on an average day? _____ minutes

Overall goal / vision: _____

- Overall goal/vision codes:**
1. Achieve/maintain a healthy weight
 2. Meal planning/healthy eating
 3. Being stronger/more physical active
 4. Manage supplement(s)/medication(s) regimen
 5. Prevent/manage diabetes (pre, DM1, DM2, GDM)
 6. Prevent/manage HTN or CVD
 7. Prevent/manage stress
 8. Smoking/vaping cessation
 9. Reduce alcohol consumption
 10. Increase food security/become food secure
 11. Other

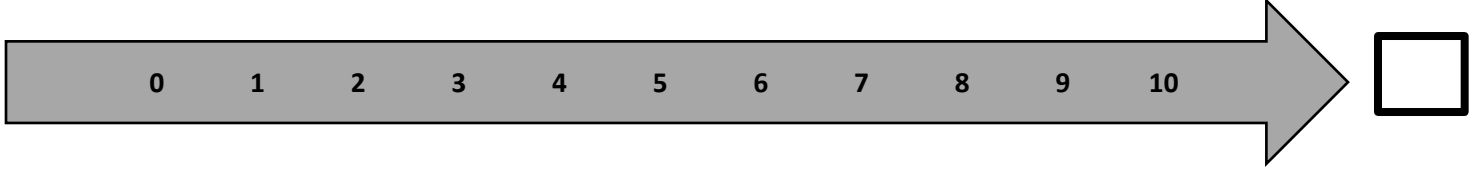
Overall Goal / Vision Topic Code: _____

Health Coaching Evaluation Form

Session 1 Goal 1-1:

Goal 1-1 Topic: _____

Confidence Ruler for Goal 1-1



Not Confident

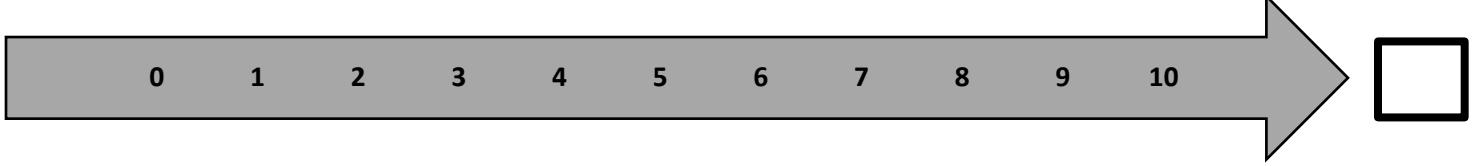
Somewhat Confident

Very Confident

Session 1 Goal 1-2:

Goal 1-2 Topic: _____

Confidence Ruler for Goal 1-2



Not Confident

Somewhat Confident

Very Confident

Goal Topic Codes:

1. ↑ Physical Activity
2. Planning, shopping, label reading
3. ↑ Fruits & vegetables
4. ↑ Whole grains
5. ↑ low- nonfat dairy, calcium foods
6. ↑ Lean proteins
7. ↓ Sugar/sodium/sat. fat, ↑ water
8. Try new recipes
9. MyPlate Plan, portion sizes
10. Limit snacking, mindful eating
11. Food sources: pantries/mobiles
12. Social
13. Medicine, supplements
14. Other

Notes:



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Health Coaching Evaluation Form

Client's Name: _____

Client's ID#: _____

Client's phone number: _____

Coach's Name: _____

Session 2 (2 weeks)

Was the session completed? Yes No

Date when session was completed: ____/____/____

Time when session was completed: ____:____ am or pm

Enter date/time of prior attempts:

	Date	Time
1 st		
2 nd		
3 rd		

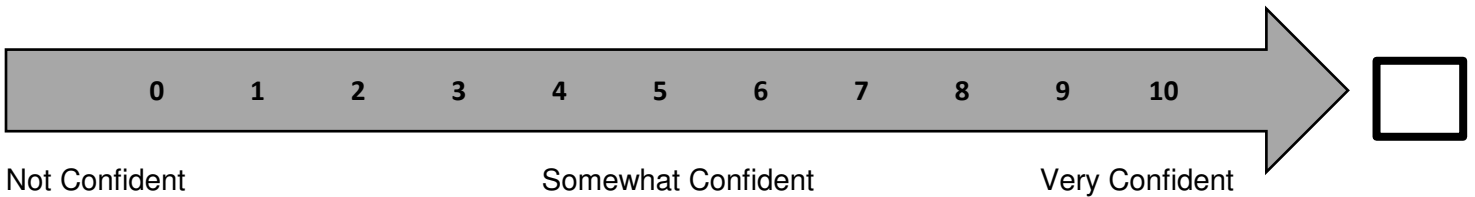
Session 1 Goal(s):

1. Percent Goal 1-1 Completed _____%
2. Percent Goal 1-2 Completed _____%

Session 2 Goal 2-1:

Goal 2-1 Topic: _____

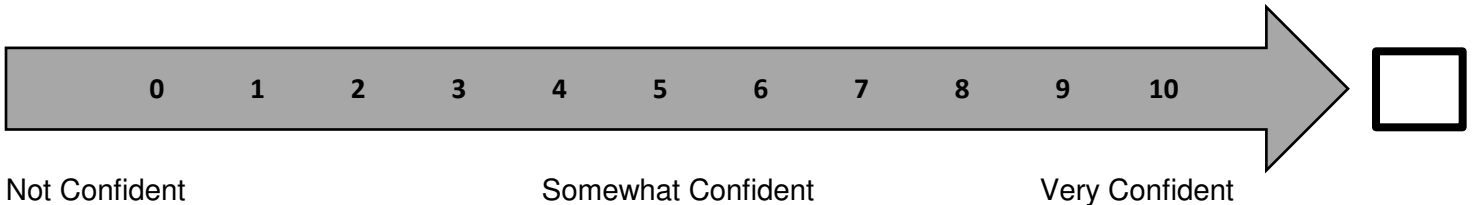
Confidence Ruler for Goal 2-1



Session 2 Goal 2-2:

Goal 2-2 Topic: _____

Confidence Ruler for Goal 2-2



Notes: _____

Health Coaching Evaluation Form

Client's Name: _____

Client's ID#: _____

Client's phone number: _____

Coach's Name: _____

Session 3 (3 weeks)

Was the session completed? Yes No

Date when session was completed: ____/____/____

Time when session was completed: ____:____ am or pm

Enter date/time of prior attempts:

	Date	Time
1 st		
2 nd		
3 rd		

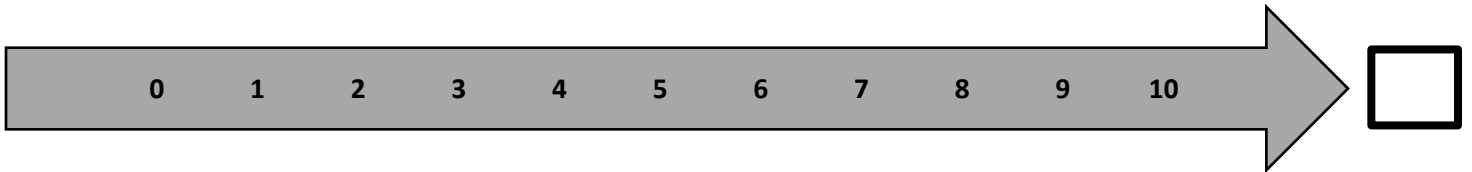
Session 2 Goal(s):

1. Percent Goal 2-1 Completed _____%
2. Percent Goal 2-2 Completed _____%

Session 3 Goal 3-1:

Goal 3-1 Topic: _____

Confidence Ruler for Goal 3-1



Not Confident

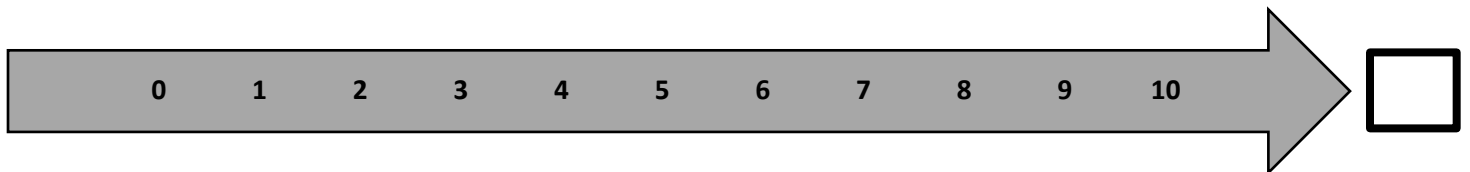
Somewhat Confident

Very Confident

Session 3 Goal 3-2:

Goal 3-2 Topic: _____

Confidence Ruler for Goal 3-2



Not Confident

Somewhat Confident

Very Confident

Notes: _____



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Health Coaching Evaluation Form

Client's Name: _____

Client's ID#: _____

Client's phone number: _____

Coach's Name: _____

Session 4 (4 weeks)

Was the session completed? Yes No

Date when session was completed: ____/____/____

Time when session was completed: ____:____ am or pm

Enter date/time of prior attempts:

	Date	Time
1 st		
2 nd		
3 rd		

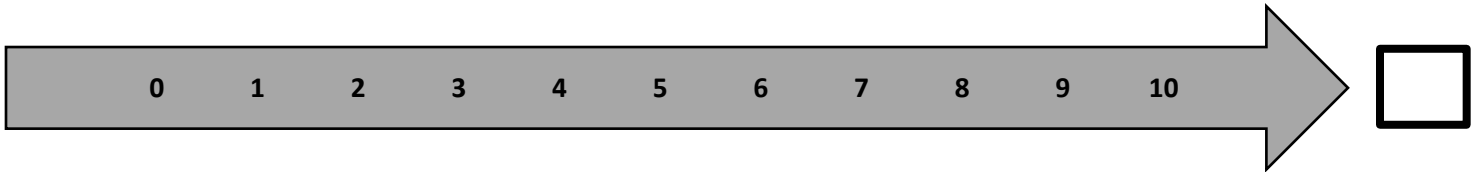
Session 3 Goal(s):

1. Percent Goal 3-1 Completed _____ %
2. Percent Goal 3-2 Completed _____ %

Session 4 Goal 4-1:

Goal 4-1 Topic: _____

Confidence Ruler for Goal 4-1



Not Confident

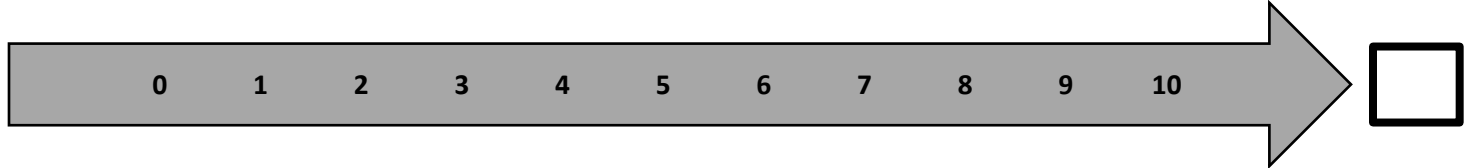
Somewhat Confident

Very Confident

Session 4 Goal 4-2:

Goal 4-2 Topic: _____

Confidence Ruler for Goal 4-2



Not Confident

Somewhat Confident

Very Confident

Notes: _____

Health Coaching Evaluation Form

Client's Name: _____

Client's ID#: _____

Client's phone number: _____

Coach's Name: _____

Session 5 (5 weeks)

Was the session completed? Yes No

Date when session was completed: ___/___/___

Time when session was completed: ___:___ am or pm

Enter date/time of prior attempts:

	Date	Time
1 st		
2 nd		
3 rd		

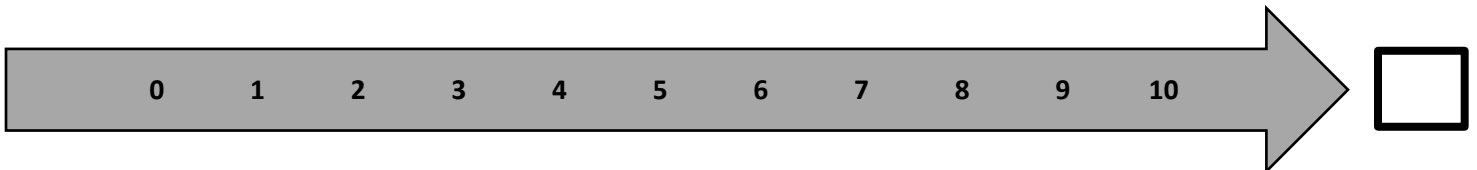
Session 4 Goal(s):

1. Percent Goal 4-1 Completed _____ %
2. Percent Goal 4-2 Completed _____ %

Session 5 Goal 5-1:

Goal 5-1 Topic: _____

Confidence Ruler for Goal 5-1



Not Confident

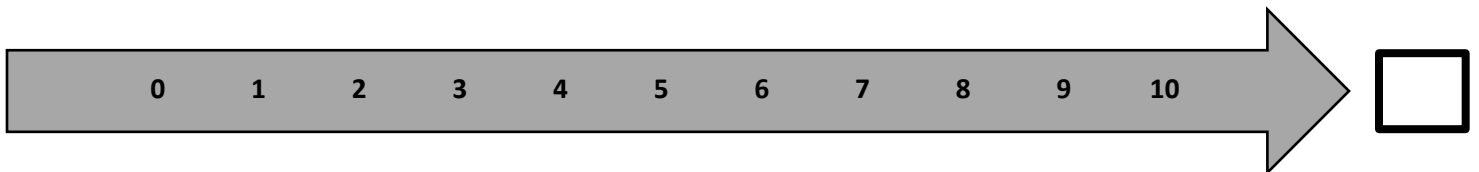
Somewhat Confident

Very Confident

Session 5 Goal 5-2:

Goal 5-2 Topic: _____

Confidence Ruler for Goal 5-2



Not Confident

Somewhat Confident

Very Confident

Notes: _____

Health Coaching Evaluation Form

Client's Name: _____

Client's ID#: _____

Client's phone number: _____

Coach's Name: _____

Session 6 (6 weeks)

Was the session completed? Yes No

Date when session was completed: ____/____/____

Time when session was completed: ____:____ am or pm

Enter date/time of prior attempts:

	Date	Time
1 st		
2 nd		
3 rd		

Ask behavior questions:

1. How often do you eat food from each food group every day? (Food groups include dairy, grains, fruits, vegetables, and protein)

Never Seldom Sometimes Most Times Always

2. During the past week, how many cups of fruit did you eat on an average day?

Cups: None 1/2 1 1 1/2 2 2 1/2 3 3 1/2 or more

3. How often do you eat more than one kind of fruit each day?

Never Seldom Sometimes Most Times Always

4. During the past week, how many cups of vegetables did you eat on an average day?

Cups: None 1/2 1 1 1/2 2 2 1/2 3 3 1/2 or more

5. How often do you eat more than one kind of vegetable each day?

Never Seldom Sometimes Most Times Always

6. When you drink milk, how often do you choose:

Whole milk (full fat) or reduced fat (2%) milk

Low-fat (1%) milk or fat-free (skim) milk

(including soy or almond milk)

Never	Seldom	Some-times	Most Times	Always	Do Not drink milk
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. When you eat yogurt, how often do you choose:

Whole milk yogurt

Low-fat or nonfat yogurt

Never	Seldom	Some-times	Most Times	Always	Do Not eat yogurt
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. When you eat rice, how often do you choose:

Brown rice

White rice

Never	Seldom	Some-times	Most Times	Always	Do Not eat rice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. When you eat pasta, how often do you choose:

Whole grain/wheat pasta

Regular pasta

Never	Seldom	Some-times	Most Times	Always	Do Not eat pasta
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. When you eat bread or tortillas, how often do you choose:

Whole grain/wheat bread or tortillas

White bread or flour tortillas

Never	Seldom	Some-times	Most Times	Always	Do Not eat bread/tortillas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. When you eat cereal, how often do you choose:

Never	Seldom	Some-times	Most Times	Always	Do Not eat cereal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Coaching Evaluation Form

Whole grain cereals (toasted oats, bran, granola, oatmeal)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Refined grain cereals (corn flakes, puffed rice)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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12. When you eat chicken or turkey, how often do you choose:

Skinless chicken or turkey

Chicken or turkey with skin

Never	Seldom	Some-times	Most Times	Always	Do Not eat chicken/turkey
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. When you eat ground beef, how often do you choose:

90% lean or greater

85% or 80% lean or less

Never	Seldom	Some-times	Most Times	Always	Do Not eat ground beef
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. How often do you eat sausage, bacon, or hot dogs?

Never
 Seldom
 Sometimes
 Most Times
 Always

15. During the past week, how many 1 cup servings of sugar-sweetened beverages did you drink on an average day? (1 cup serving = 8 ounces)

Cups: None 1 2 3 4 5 or more

16. How often do you eat low-sodium options when eating packaged foods such as canned soups or vegetables, pre-packaged rice, frozen meals, etc.?

Never
 Seldom
 Sometimes
 Most Times
 Always

17. How many minutes of physical activity do you get on an average day? _____ minutes

Session 5 Goal(s):

1. Percent Goal 5-1 Completed _____%
2. Percent Goal 5-2 Completed _____%

Notes: _____

Address for incentive:



Was the incentive sent to participant? Yes No

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