

Health Coaching: Eating Smart • Being Active®

Client's Name: _____

Client's ID#: _____

Client's phone number: _____

Coach's Name: _____

Client's email: _____

Did the client attend ESBA Workshop/NES? Yes No If yes, what topic? _____

Signed up online? Yes No Is the client participating in WISEWOMEN? Yes No

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 all food groups every day? (Food groups include dairy, grains, fruits, vegetables, and protein)

<1 time/week 1-2 times/week 3-4 times/week 5-6 times/week 7+ times/week

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

Cups: None ½ 1 1½ 2 2½ 3 3½ or more

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

<1 time/week 1-2 times/week 3-4 times/week 5-6 times/week 7+ times/week

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

Cups: None ½ 1 1½ 2 2½ 3 3½ or more

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

<1 time/week 1-2 times/week 3-4 times/week 5-6 times/week 7+ times/week

6. How often do you eat or drink the following?

<1 time/
week

1-2 times/
week

3-4 times/
week

5-6 times/
week

7+ times/
week

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

Low-fat (1%) milk or fat-free (skim) milk (including soy or almond milk)

Regular (whole milk) yogurt

Low-fat or nonfat yogurt

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7. How often do you eat the following?	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Brown rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grain/wheat pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grain/wheat bread or tortillas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White bread or flour tortillas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grain cereals (toasted oats, bran, granola, oatmeal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refined grain cereals (corn flakes, puffed rice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. How often do you eat the following?	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Skinless chicken or turkey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken or turkey with skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ground beef 90% lean or greater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ground beef 85% or 80% lean or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pork or beef: sausage or bacon or hot dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. 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

10. How often do you:	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Eat convenience or fast foods (Premade frozen or boxed meals, boxed or bagged snacks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add salt when cooking or eating food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat low-sodium packaged food options such as canned soups or vegetables, pre-packaged rice, frozen meals, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare foods by frying/sautéing/deep-frying (not including air frying)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. How often do you:	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Use the "Nutrition Facts" on the food label to make food choices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan meals ahead of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compare prices before you buy food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shop with a grocery list?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How many minutes of physical activity do you get on an average week? _____ 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

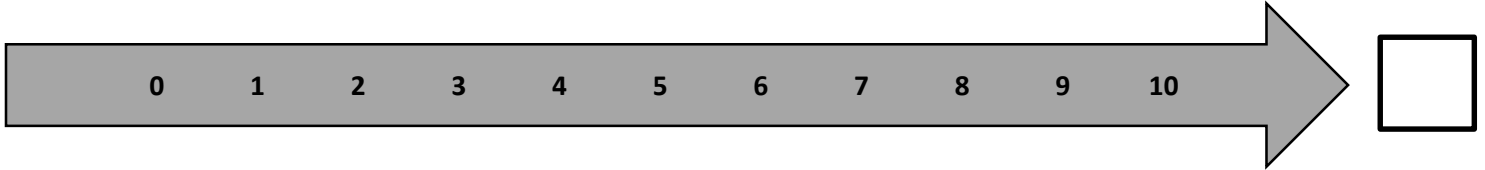
Overall Goal / Vision Topic Code: _____

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Session 1 Goal 1-1:

Goal 1-1 Topic: _____

Confidence Ruler for Goal 1-1



Not Confident

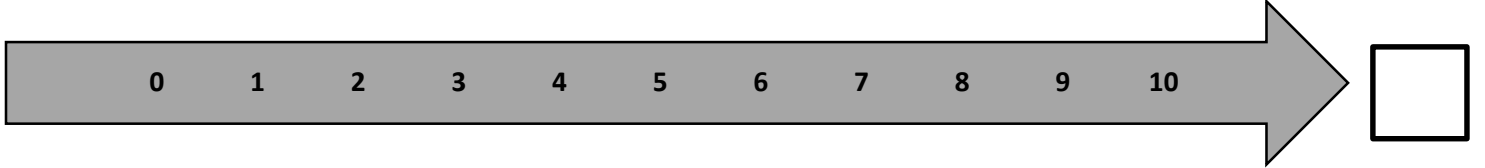
Somewhat Confident

Very Confident

Session 1 Goal 1-2:

Goal 1-2 Topic: _____

Confidence Ruler for Goal 1-2



Not Confident

Somewhat Confident

Very Confident

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:

Health Coaching: Eating Smart • Being Active®

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):

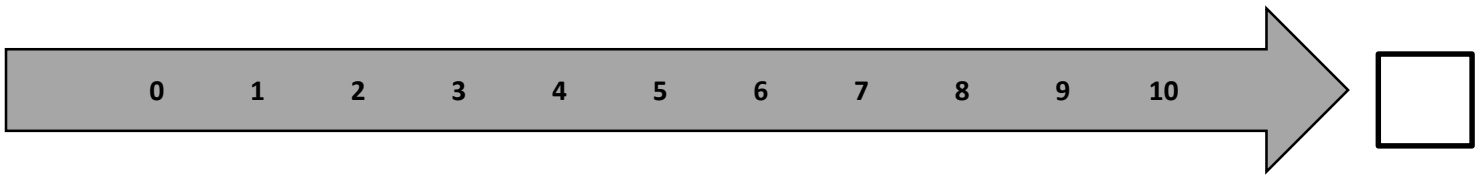
1. Percent Goal 1-1 Completed _____ %

2. Percent Goal 1-2 Completed _____ %

Session 2 Goal 2-1:

Goal 2-1 Topic: _____

Confidence Ruler for Goal 2-1



Not Confident

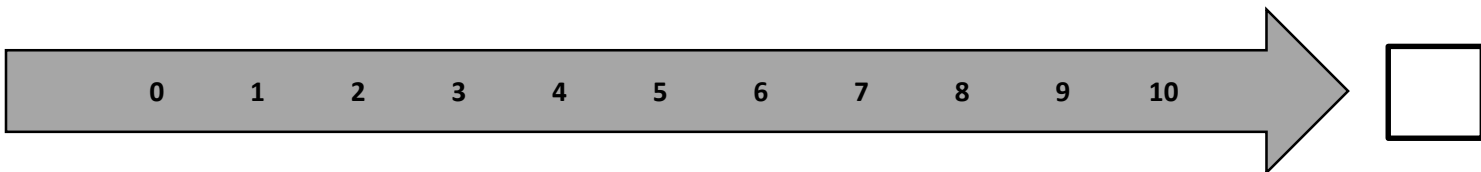
Somewhat Confident

Very Confident

Session 2 Goal 2-2:

Goal 2-2 Topic: _____

Confidence Ruler for Goal 2-2



Not Confident

Somewhat Confident

Very Confident

Notes: _____

Health Coaching: Eating Smart • Being Active®

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		

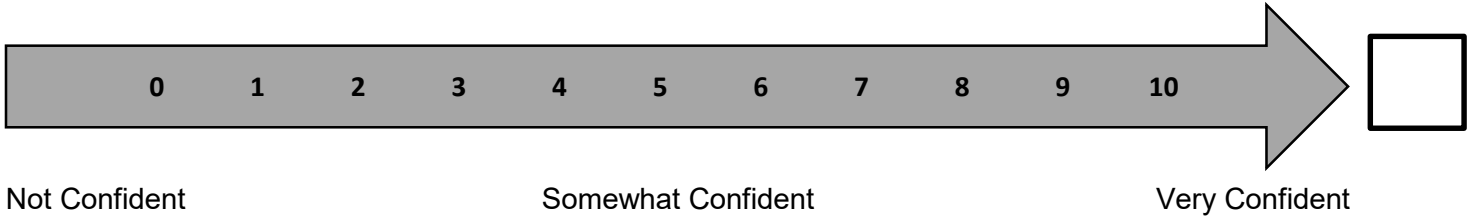
Session 2 Goal(s):

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

Session 3 Goal 3-1:

Goal 3-1 Topic: _____

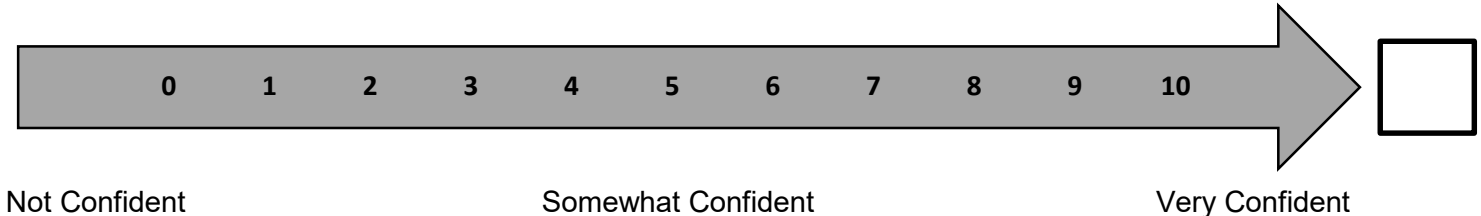
Confidence Ruler for Goal 3-1



Session 3 Goal 3-2:

Goal 3-2 Topic: _____

Confidence Ruler for Goal 3-2



Notes: _____

Health Coaching: Eating Smart • Being Active®

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

Follow-up questions asked for topic: Yes No

(Obtain the follow-up questionnaire for original session attended and ask the questions for 6-week follow-up)

Enter date/time of prior attempts:

	Date	Time
1 st		
2 nd		
3 rd		

Session 3 Goal(s):

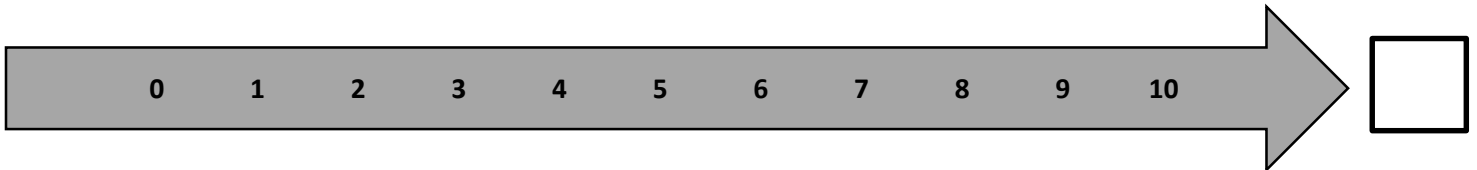
1. Percent Goal 3-1 Completed _____%

2. Percent Goal 3-2 Completed _____%

Session 4 Goal 4-1:

Goal 4-1 Topic: _____

Confidence Ruler for Goal 4-1



Not Confident

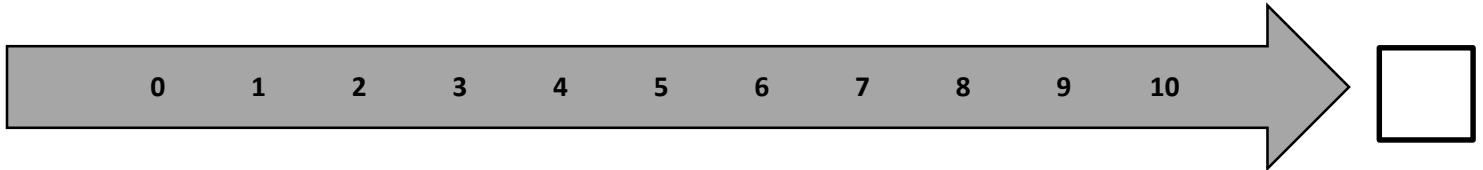
Somewhat Confident

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: Eating Smart • Being Active®

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):

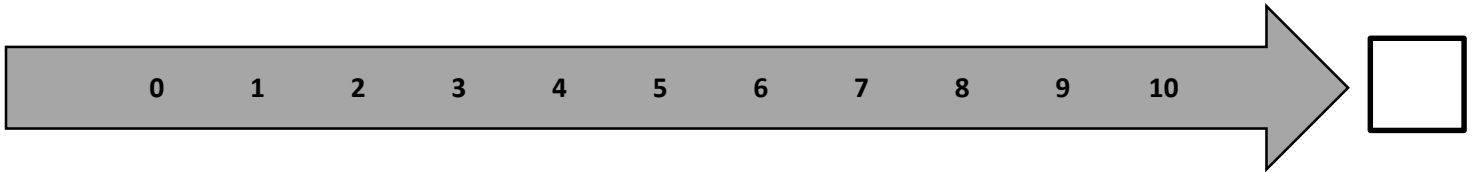
1. Percent Goal 4-1 Completed _____ %

2. Percent Goal 4-2 Completed _____ %

Session 5 Goal 5-1:

Goal 5-1 Topic: _____

Confidence Ruler for Goal 5-1



Not Confident

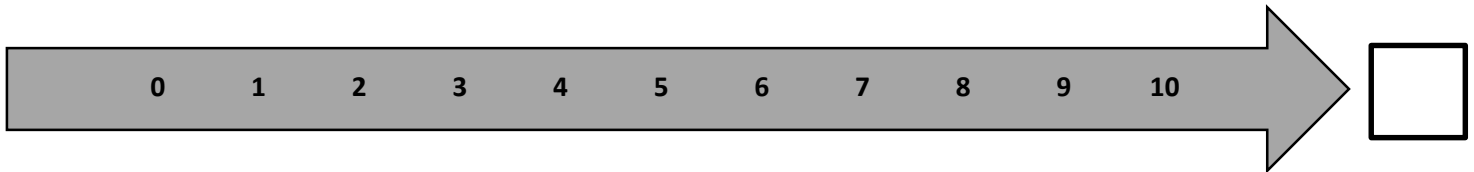
Somewhat Confident

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: Eating Smart • Being Active®

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 all food groups every day? (Food groups include dairy, grains, fruits, vegetables, and protein)

<1 time/week 1-2 times/week 3-4 times/week 5-6 times/week 7+ times/week

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

Cups: None ½ 1 1½ 2 2½ 3 3½ or more

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

<1 time/week 1-2 times/week 3-4 times/week 5-6 times/week 7+ times/week

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

Cups: None ½ 1 1½ 2 2½ 3 3½ or more

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

<1 time/week 1-2 times/week 3-4 times/week 5-6 times/week 7+ times/week

6. How often do you eat or drink the following?

	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Whole milk (full fat) or reduced fat (2%) milk	<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"/>
Regular (whole milk) yogurt	<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"/>

7. How often do you eat the following?

	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Brown rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grain/wheat pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grain/wheat bread or tortillas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
White bread or flour tortillas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whole grain cereals (toasted oats, bran, granola, oatmeal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Refined grain cereals (corn flakes, puffed rice)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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8. How often do you eat the following?	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Skinless chicken or turkey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken or turkey with skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ground beef 90% lean or greater	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ground beef 85% or 80% lean or less	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pork or beef: sausage or bacon or hot dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. 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

10. How often do you:	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Eat convenience or fast foods (Premade frozen or boxed meals, boxed or bagged snacks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Add salt when cooking or eating food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat low-sodium packaged food options such as canned soups or vegetables, pre-packaged rice, frozen meals, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepare foods by frying/sautéing/deep-frying (not including air frying)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. How often do you:	<1 time/ week	1-2 times/ week	3-4 times/ week	5-6 times/ week	7+ times/ week
Use the "Nutrition Facts" on the food label to make food choices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Plan meals ahead of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compare prices before you buy food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shop with a grocery list?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. How many minutes of physical activity do you get on an average week? _____ 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

Printed