

St. Clair County Community Mental Health



InSHAPE Intake Form

Self-Health Action Plan for Empowerment

Name: _____ Case Number: _____

Date of Orientation: _____ Height: _____ Weight: _____

Medical History

Please list any conditions or concerns that may limit physical activity or that should be known for emergency purposes, such as diabetes, heart attack, recent surgery within the past six months, or other relevant medical history.

Do you currently have, or have you previously had, any of the following conditions?

- | | | | | |
|--|---|---------------------------------------|---|--|
| ☐ Asthma | ☐ Hypertension | ☐ Arthritis | ☐ Diabetes (I or II) | ☐ Stroke |
| ☐ Heart Disease | ☐ High Cholesterol | ☐ Osteoporosis | ☐ COPD | ☐ Anemia |
| ☐ Allergies | ☐ Kidney Disease | ☐ Gout | ☐ Fibromyalgia | ☐ Liver Disease |

Do you currently use any substances, including alcohol, tobacco, or marijuana?

☐ Yes ☐ No

If yes, please specify the substance(s) and frequency of use: _____

Do you drink caffeine?

☐ Yes ☐ No

If yes, how many do you consume per day? _____

Do you smoke/vape?

☐ Yes ☐ No ☐ Tobacco ☐ Marijuana

Frequency/amount: _____

Do you drink alcohol?

☐ Yes ☐ No

Type/frequency/amount: _____

Review the medication list with the person. Ask whether they are taking any additional medications and document what they are taking: _____

Are you taking any regular over-the-counter medications? _____

What time do you go to bed at night? _____

What time do you wake up? _____

Do you use an alarm clock to wake up? ☐ Yes ☐ No

Please describe a typical day: _____

How many hours on average do you spend sitting? _____

On average, how many hours per week do you spend exercising? _____

Do you take frequent naps? ☐ Yes ☐ No

If yes, how long are your naps? _____

What do you like to do for fun? _____

One year from now, what would you like your InSHAPE® progress to look like? For example, weight loss, increased strength, or improved endurance. _____

Physical Health Risk Assessment Form

Have you ever been told that you have a heart condition? ☐ Yes ☐ No

Have you ever had a stroke? ☐ Yes ☐ No

Do you ever have unexplained pains in your chest at rest or during physical exercise? ☐ Yes ☐ No

Do you suffer from fainting or dizziness? ☐ Yes ☐ No

Do you have asthma? ☐ Yes ☐ No If yes, do you use a rescue inhaler? ☐ Yes ☐ No

Do you suffer from Type I or Type II diabetes? ☐ Yes ☐ No

Do you have any major muscle or joint conditions that may limit you or be aggravated by physical activity?
☐ Yes ☐ No

Do you suffer from high blood pressure over 140/90 or low blood pressure below 100/80?
☐ High blood pressure ☐ Low blood pressure ☐ Unsure ☐ No

Do you have high cholesterol, or has a doctor told you that it is elevated? ☐ Yes ☐ No

Have you experienced unusual pain or discomfort in your chest, neck, jaw, arms or other areas that may be due to heart problems? ☐ Yes ☐ No

Have you experienced unusual fatigue or shortness of breath at rest, during usual activities, or during mild-moderate exercise? ☐ Yes ☐ No

Do you ever have difficulty breathing? ☐ Yes ☐ No

Have you ever experienced rapid fluttering or throbbing of the heart? ☐ Yes ☐ No

Do you have a family history of heart disease? ☐ Yes ☐ No

If yes, please identify the relationship: ☐ Mother ☐ Father ☐ Grandparent ☐ Sibling

Have you spent time in the hospital for any medical condition/illness/injury in the last year? ☐ Yes ☐ No

Nutritional Assessment

What is your weekly food budget? _____

What support are you looking for with your weekly meal plan? _____

Have you ever followed a modified diet? ☐ Yes ☐ No

If yes, explain: _____

Has a medical provider ever diagnosed you with a food allergy or intolerance? ☐ Yes ☐ No

If yes, explain: _____

Have you ever met with a registered dietician? ☐ Yes ☐ No

Would you be interested in meeting with a dietician? ☐ Yes ☐ No

What would you identify as a concern with your eating habits? (i.e. eating out at fast food restaurants several times a week, eating boxed or frozen foods, don't like a certain type of food) _____

How many glasses of water do you drink daily? ☐ 0-3 ☐ 3-6 ☐ 6-9 ☐ 9+

Where does most of your food come from?

☐ Grocery store ☐ Food pantry ☐ Restaurants ☐ Convenience stores ☐ Dollar stores ☐ Farmers market

What equipment do you have to prepare food?

☐ Stove ☐ Microwave ☐ Hot plate ☐ Toaster/toaster oven

Who prepares your food?

☐ Self ☐ Spouse ☐ Parent ☐ Group Home Staff

How often do you dine out? _____ times per week.

What are some of the foods you crave? (i.e. sweets, salty, pizza) _____

What would you like to do with your weight?

☐ Increase ☐ Maintain ☐ Lose

Weight in the last 5 years:

Highest: _____ lbs. Lowest: _____ lbs.

Do you have an ideal weight? ☐ Yes _____ lbs. ☐ No

How many meals (and snacks) per day do you typically eat? _____

What did you eat in the last 24 hours? _____

Eating style: Based on how you eat on a regular basis, please check all that apply:

- ☐ Fast eater ☐ Dislike “healthy” foods (fruits, vegetables, lean meats) ☐ Family members have different tastes
☐ Erratic eater ☐ Emotional eater ☐ Late-night eater ☐ On the move all day ☐ Frequently plan meals/menus
☐ Love to eat ☐ Rely on convenience items ☐ Eat too much ☐ Eat too little ☐ Confused about food/nutrition
☐ Frequently eat fast food

How often do you eat? (# of times)

6-10am ____ 10am-2pm ____ 2-6pm ____ 6-10pm ____ 10pm-2am ____ 2-6am ____

How do you decide on what to eat for each meal?

Breakfast: _____

Lunch: _____

Dinner: _____

Do you understand food labels? ☐ Yes ☐ No

Have you reviewed food labels? ☐ Yes ☐ No

Would you like support learning how to read food labels? ☐ Yes ☐ No

Notes: _____

On a scale of 1–10, how ready are you to begin engaging in healthier eating habits daily?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Stages of Change

Stage of change (nutrition):

☐ Pre-contemplative ☐ Contemplative ☐ Preparation ☐ Action ☐ Maintenance

Do you currently engage in any regular physical activity? ☐ Yes ☐ No

If yes, please explain: _____

What are some types of physical activity you enjoy? _____

Past exercise experience? _____

Does anything limit you from being physically active? _____

Have you fallen in the last year?

☐ Yes ☐ No

Indicate daily stressors and the level of stress from 1 (extremely low) to 10 (extremely high):

Work _____ Family _____ Social _____ Financial _____ Health _____

Other _____ Mental Health _____ Medications _____

On a scale of 1–10, how important is it to you to make lifestyle changes?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

On a scale of 1–10, how confident are you that you will achieve your goals?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Stage of change (exercise):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

☐ Pre-contemplative ☐ Contemplative ☐ Preparation ☐ Action

What are the three biggest barriers to achieving your goals?

1. _____

2. _____

3. _____

What are the three biggest strengths to achieving your goals?

1. _____

2. _____

3. _____

GOALS

Goal 1: _____

Objective: _____

Intervention: _____

Goal 2: _____

Objective: _____

Intervention: _____

Individual Self-Health Action Plan for Empowerment

My long-term health goal(s): _____

How will reaching the goal(s) change my life: _____

Healthy Eating Objective: _____

To reach my long-term goal, I will do the following over the next week:

What: _____

When: _____

Where: _____

With whom: _____

Exercise Objective: _____

To reach my long-term goal, I will do the following over the next week:

What: _____

When: _____

Where: _____

With Whom: _____

Smoking Cessation or Other Health Management Goals: _____

To reach my long-term goal, I will do the following over the next week:

What: _____

When: _____

Where: _____

With Whom: _____

Participant Signature: _____ Date: _____

Mentor Signature: _____ Date: _____

©