

WELLNESS ASSESSMENT

Date: _____

Instructions: Please complete these forms and bring to your next appointment.



About Me

Name: _____ Age: _____

Where do I live? _____ How long have I had HIV? _____

Fun fact about me: _____

1 My Health Hopes

What is important to me and my health?

What is an ideal day for me?

3 My Health Behaviors

Behaviors that I've done over the past 3 months (*check all that apply*)

- Did not drink alcohol OR reduced the amount of alcohol
- Did not use drugs OR Reduced the amount of drugs
- Used a condom regularly
- Entered a substance abuse treatment program
- Attended a support group
- Saw my medical provider for a check up
- Exercised 2-3 times a week
- Ate more fruits and vegetables
- Changed my diet

If you have more personal information you would like to share, please speak with your provider or social worker.

2 My Health Reality

What are my health strengths? *Example: exercise regularly*

What are my health challenges?

My Lab Results:

Date: _____ CD4: _____ Viral Load: _____

4 My Healthcare

In general, what gets in the way of improving my health?

- | | |
|--|---|
| <input type="radio"/> Depression/Anxiety | <input type="radio"/> Living situation |
| <input type="radio"/> Mental health issues | <input type="radio"/> Substance use |
| <input type="radio"/> Side effects of medications | <input type="radio"/> Not sure |
| <input type="radio"/> Scheduling problems | <input type="radio"/> Nothing |
| <input type="radio"/> Forget or miss my appointments | <input type="radio"/> Other: <input type="text"/> |

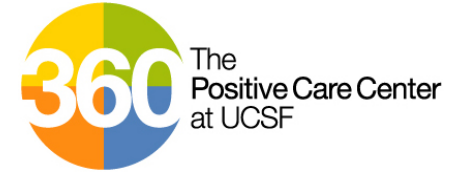
In the past 7 days, how many times did I miss my HIV medications?

- 0 times 1-2 times 3-4 times 5 or more times

WELLNESS ACTION PLAN

Date: _____

Instructions: Please complete these forms and bring to your next appointment. You and your provider can work on the action steps together.



About Me

Name: _____ Age: _____

Weight: _____ Height: _____ BP: _____

What will inspire me to work on this plan? _____

Plan Timing

Start Date: _____ Check-in Date: _____

1 My Goal

What is my health goal?

How important is this health goal to me?

Unimportant Neutral Important
1 2 3 4 5

How confident am I that I can achieve this goal?

Unlikely Neutral Likely
1 2 3 4 5

2 My Health Reality

Who can support my health goal? How can I improve this?

3 My Health Behaviors

What behaviors will support my health goal?

Please work with your provider to develop steps toward your goal. Then rate how likely it will be for you to achieve each step (1 is unlikely, 3 is neutral, 5 is likely).

STEP 1				
1	2	3	4	5

STEP 2				
1	2	3	4	5

STEP 3				
1	2	3	4	5

STEP 4				
1	2	3	4	5

STEP 5				
1	2	3	4	5

WELLNESS PROGRESS

Date: _____



Instructions: Save this form, track your progress, and bring to your clinic visits.

Using the calendar below, work with your provider to develop either a weekly or monthly plan for reaching your goal. Add any comments, successes or challenges you have in meeting these steps.

About Me

Name: _____ Age: _____

What will inspire me to work on this plan? _____

Plan Timing

Start Date: _____ Check-in Date: _____

Weekly Monthly

Goal Achieved: _____

1 My Goal

STEP 1	STEP 2	STEP 3	STEP 4	STEP 5
