**MY STRENGTHS, NEEDS AND WORRIES (First Session) NAME:…………………………………………**

**Facilitator Names: XXXXXXXX**

**Date: XXXXXXXX**

**Please circle the level that applies to you on the graph!**(1= a little; 8= a lot)

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| **Q.1**  How much do I know about my health condition? |  | **Q.2**  How much do I know about my medicines and treatment ? |  |
| **Q.3**  Do you take your medications regularly as prescribed by your Doctor |  | **Q.4**  I feel confident that I am listened to when I go to visit my Doctor? |  |
| **Q.5**  Do you feel your culture is respected when you visit your Doctor? |  | **Q.6**  Do you attend your appointments? |  |
| **Q.7**  How well do you recognise when you are getting sick? |  | **Q.8**  Do you know what to do when symptoms arise? |  |
| **Q.9**  Are you able to move around easily and do the things you like doing? |  | **Q.10**  Do you cope with how your health affects your feelings? |  |
| **Q.11**  Can you easily visit your family and friends? |  | **Q.12**  Overall, do you lead a healthy life? |  |
| **Q.13**  How confident do you feel at the moment about making changes in your life to better manage your health? |  | **COMMENTS** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Do you worry about your long term condition/health problem?**  **YES/NO (circle one)** | **If yes, what is it you worry about?** |
| **Do you have a goal(s) for the next six months to improve your health?**  **YES/NO (circle one)** | **If yes, what is the goal?** |