**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?**  |