SHARED CARE PLAN
INITIAL INTAKE FORM

NAME: _____ **DATE:** _____

1. My overall life goal(s) are:

_____

_____

2. My overall health goals are:

_____

_____

3. My reasons for choosing these goals are:

_____

_____

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4. Factors that may be affecting my health:
***(check all that apply)*:**

- ☐ Difficulty in managing a chronic condition
- ☐ Financial problems
- ☐ Low level of energy/feeling fatigue
- ☐ Personal Safety
- ☐ Thinking or memory problems
- ☐ Embarrassment/Stigma
- ☐ Tobacco use
- ☐ Access to healthcare services
- ☐ Alcohol or other substance use
- ☐ Taking my medications
- ☐ Body weight
- ☐ Family Stressors
- ☐ Emotional Issues
- ☐ Mental well-being (depression, anxiety)
- ☐ Other _____

_____

_____

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5. From your answers to #4, please list those factors here and rate their importance in affecting your health goal:

IMPORTANCE SCALE *(1=low and 5=high)*

_____ 1 2 3 4 5

_____ 1 2 3 4 5

_____ 1 2 3 4 5

SHARED CARE PLAN | INITIAL INTAKE FORM

6. Which of these areas (if any) would you like to work on with support from your care team?

PRIORITY RATING ***(1st, 2nd, 3rd)***

_____ 1st 2nd 3rd

_____ 1st 2nd 3rd

_____ 1st 2nd 3rd

NAME OF COMMUNITY HEALTH WORKER: _____

CONTACT INFORMATION:

PHONE: _____

EMAIL ADDRESS: _____

SHARED CARE PLAN | GOALS/ACTION PLAN

CHOSEN FOCUS AREA:
List area that you would like to create an *ACTION PLAN* around:

_____

Why you are interested in addressing this area at this time:

_____

_____

Specific (what will you do) _____

Measurable (how much or how long will you do it) _____

Achievable (Is this something you feel confident that you can accomplish) _____

Realistic (Do you have a place or space that you can do this) _____

Time-Oriented (When will you plan to do this) _____

Accountability Partner: (Who can support you to complete this action plan)?

_____

How will you address barriers or challenges?

_____

_____

What personal strengths can you draw on to help reach your goal(s)?

_____

_____

What information or referrals do you need from your care team?

_____

_____

Please state your action plan out loud to your care manager/community health worker and share your confidence level in working on it between now and your next visit.

MY CONFIDENCE LEVEL FOR COMPLETING THIS ACTION STEP?

Scale 1-10

1 2 3 4 5 6 7 8 9 10

NEXT MEETING: _____ **IN PERSON** _____ **TELEPHONE** _____

SHARED CARE PLAN | GOALS/ACTION PLAN
FOLLOW UP #_____

NAME: _____ **DATE:** _____

CHOSEN FOCUS AREA:
List area that you chose to create an ACTION PLAN around:

_____

_____

_____

Related to the specific action plan, what worked well?

_____

_____

_____

What might need some tweaking or re-adjusting:

_____

_____

_____

Has anything changed in your list of "factors that may affect your health" that may need review or consideration:

_____

_____

_____

Would there be any benefit to referring to additional resources or services?

_____

_____

_____

SHARED CARE PLAN | GOALS/ACTION PLAN
FOLLOW UP #_____

ACTION PLAN ADVANCEMENT OR RE-SET:

Specific (what will you do) _____

Measurable (how much or how long will you do it) _____

Achievable (Is this something you feel confident that you can accomplish) _____

Realistic (Do you have a place or space that you can do this) _____

Time-Oriented (When will you plan to do this) _____

Accountability Partner: (Who can support you to complete this action plan)?

_____

How will you address barriers or challenges?

_____

_____

What information do you need from your care team?

_____

_____

_____

_____

Please state your action plan out loud to your care manager/community health worker and share your confidence level in working on it between now and your next visit.

MY CONFIDENCE LEVEL FOR COMPLETING THIS ACTION STEP?

Scale 1-10

1 2 3 4 5 6 7 8 9 10

NEXT MEETING: _____ **IN PERSON** _____ **TELEPHONE** _____