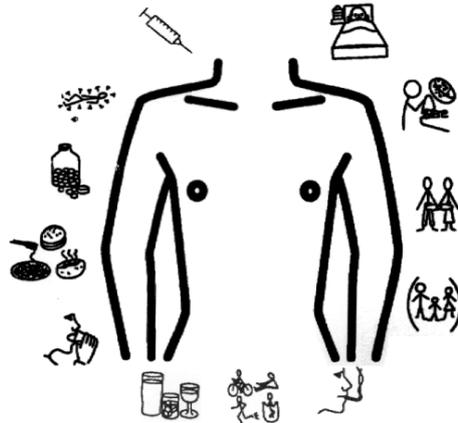


BODYWISE



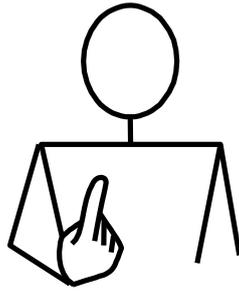
Physical Health and Well Being Health Action Plan

Bodywise Health and Wellbeing Health Action Plan

Section 1	All About Me
Section 2	People Who Help Me
Section 3	My Health
Section 4	My Lifestyle
Section 5	Courses and Training

SECTION 1

All About Me



All About Me – Page 1



NAME



.....



BIRTHDAY



.....



ADDRESS

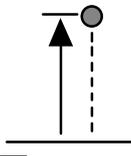
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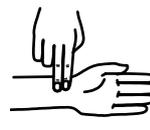


All About Me - Page 2

 Height

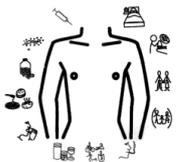
 Weight

 Blood Pressure

 Pulse

 Body Mass Index (BMI)
.....

 Waist Circumference
.....



All About Me – Page 3

 People Who Help Me

 My Carers at home

 My GP is
Health Centre

GP Contact Record



Date	Doctor seen	Reason for visit	Outcome

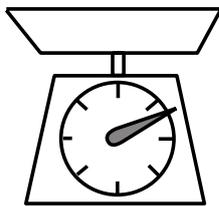
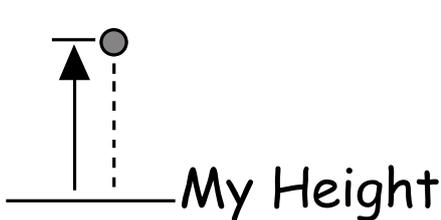
GP Contact Record



Date	Doctor seen	Reason for visit	Outcome



All About Me - Physical Health Recordings



DATE	WEIGHT	+	-

Section 1 All About Me Weight Record



All About Me - Physical Health Recordings

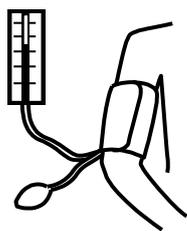


DATE	BMI	+	-

Section 1 All About Me BMI Record



All About Me - Physical Health Recordings



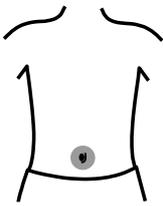
My Blood Pressure

DATE	Blood Pressure	+	-

Section 1 All About Me BP Record



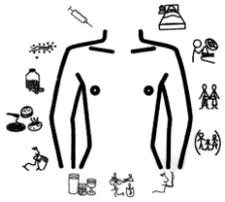
All About Me - Physical Health Recordings



My Waist Measurement

DATE	Waist Measurement	+	-

Section 1 All About Me Waist Measurement



All About Me - Physical Health Recordings



DATE	Pulse	+	-

Section 1 All About Me Pulse Record

SECTION 2

People Who Help Me





**Professional and Name
Contact Details**



.....

Address



.....

Telephone

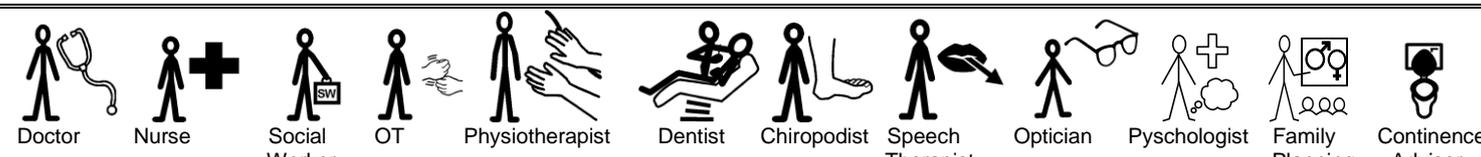


.....

Why do I see this person?



.....



**Professional and Name
Contact Details**



.....

Address



.....

Telephone



.....

Why do I see this person?



.....

Record of Appointments

Date 	Record of Consultation 	Any actions 

Record of Appointments

Date 	Record of Consultation 	Any actions 

Other Specialist Health Contacts

Professional

Name

Contact Details

Address

.....
.....
.....

Telephone

Why do I see this person?

.....
.....
.....

Other Specialist Health Contacts

Professional

Name

Contact Details

Address

.....
.....
.....

Telephone

Why do I see this person?

.....
.....
.....



Health Action Plan

Date	Identified Need	Actions	Signed	Review Date



Health Action Plan

Date	Identified Need	Actions	Signed	Review Date

SECTION 3

My Health



My Health Page 1



Medical Diagnosis.

.....

.....

.....



Health History

.....

.....

.....

.....



My Health - Page 4



Health Checks.

Date of last full medical examination

.....

Carried out by who and where

.....

Did your last medical examination include blood checks and if so for what?

.....
.....
.....
.....

Annual Health Screen Page 5

Height

Weight

BMI

BP

Pulse

Waist Circumference.....

ECG if indicated

Blood Screening

Plasma drug level monitoring as required.....

FBC..... LFT..... U and E's..... TFT's.....

Random Glucose..... Prolactin if required.....

Cholestrol if required.....

Urinalysis.....

Immunisations up to date? if not anything required.....

Medication Review completed by who and when.....

Does the client suffer any side effects from their current medication.....

.....

Was a general physical examination completed if yes when and by whom.....

Was anything detected that required further investigation.....

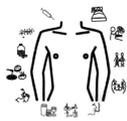
.....

Any current health needs reported by client.....

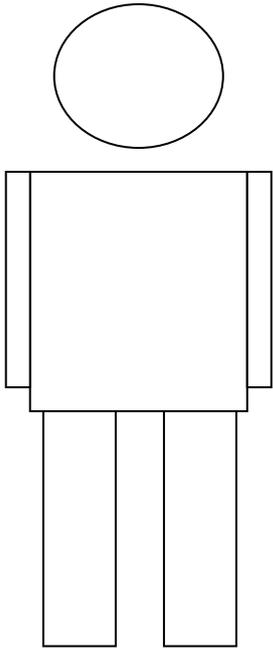
Opticians.....

Dentist.....

Audiology.....



Symptoms Checklist



1
2
3
4
5

My Health – Page 7

Sexual Health Women.

- Are you sexually active?.....
- If yes do you use or take contraception?.....
- Do you menstruate?.....
- If yes are your periods regular?.....
- Do you experience excessive pain or discomfort during your period.....
- Do you suffer with PMT?.....
- Have you had any sex education?.....
- If no would you like to attend a course on sexuality and relationships?.....
- Have you had a cervical smear in the past 5 years?
- If no would you be prepared to let us organise one for you?.....
- Have you been through the menopause?.....
- Are you experiencing any menopausal symptoms.....
-
- Do you take HRT?.....

My Health Page 8

Sexual Health Men.

Do you examine your own testicles?.....

If no has their been an examination by a GP?.....

Do you suffer from any pain or discomfort in your genitals?.....

Are You Sexually active?.....

Do you use contraception?.....

Do you require any sex education?.....

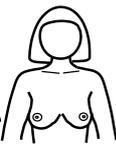
If yes would you be prepared to attend a sex education course?.....

If client is over 50 has he had a prostate examination?.....

If yes when and by whom.....

Sexual Health Screening

Breast Exams



Date	Where and by who?	Results	Next Due

Sexual Health Screening

Smear Tests



Date	Where and by who?	Results	Next Due

Sexual Health Screening

Prostate Exam



Date	Where and by who?	Results	Next Due

Sexual Health Screening

Testicular Exam



Date	Where and by who?	Results	Next Due

Additional Medications Used

DATE	MEDICATION	REASON

SECTION 4

My Lifestyle



My Weekly Timetable.

	Morning	Afternoon	Evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Your habits that may not be good for your health.

Alcohol.

Do you drink alcohol

If Yes how many units per week 1- 7, 8 – 14, 15 – 21, 22 – 28, 29 – 35.

Do You feel that you have a problem with your alcohol consumption.....

Smoking.

Do you smoke cigarettes, cigars or a pipe.....

If yes what type and how many.....

Would you be interested in quitting or reducing the amount that you smoke

Illicit Substances.

Do you take any illicit substances.....

If yes please state what and how often.....

Would you like help with quitting or reducing your illicit substance intake.....

Diet and Nutrition. Page 3

Do you have a special diet for any particular reason.....

If Yes Please describe.....
.....
.....

Do you have breakfast, lunch and dinner every day.....

Do you cook for yourself or does someone make your meals for you?.....

If someone else does, who?.....

Do you have five a day?

How would you describe your diet, Healthy, Sometimes Healthy, Unhealthy.....

Would you describe yourself as Overweight, About Right or Underweight.....

How much fluid on average do you drink each day.....

Can you describe what a healthy meal should consist of.....

Exercise – Page 4

How much and what sort of exercise do you take on a regular basis.



Swimming.....



Walking.....



Dancing.....



Keep Fit.....



Running or Jogging.....



Horse riding.....



Football.....



Other Activities.....

My Lifestyle

My Diet Action Plan

What do I need to do?	Who is going to help me?	I will do this by?	Did I do it?

My Lifestyle

My Exercise Action Plan

What do I need to do?	Who is going to help me?	I will do this by?	Did I do it?

My Lifestyle

My Alcohol Action Plan

What do I need to do?	Who is going to help me?	I will do this by?	Did I do it?

My Lifestyle

My Illicit Substances Action Plan

What do I need to do?	Who is going to help me?	I will do this by?	Did I do it?

Section 5



Health and Wellbeing Courses and Training



Courses and Training I have done

Course Title	
What was it about? ?	
When did you do it? ?	
Who were the tutors? ?	



Courses and Training I have done

Course Title	
What was it about? ?	
When did you do it? ?	
Who were the tutors? ?	