# Diabetes Education Program Assessment Form

**Name:** ___________________________________________  **Date:** __________________________

1. **How did you learn about our Diabetes Self-Management Program?**
   - [ ] Friend/Family
   - [ ] Radio
   - [ ] Medical Provider
   - [ ] Event
   - [ ] Flyer
   - [ ] Online
   - [ ] Other

2. **Highest level of education completed:**
   - [ ] Elementary school
   - [ ] Some high school
   - [ ] High school graduate/GED
   - [ ] Some College
   - [ ] College Degree
   - [ ] Post Graduate

3. **Who is your primary support person?**
   - [ ] Self
   - [ ] Spouse
   - [ ] Other ____________________________

4. **Do you live alone?**
   - [ ] Yes
   - [ ] No - who do you live with? ____________________________

5. **What is your learning preference?**
   - [ ] Reading
   - [ ] Listening
   - [ ] Hands on demonstration
   - [ ] Visual

6. **Do any of the following apply to you?**
   - [ ] English second language
   - [ ] Unable to read well
   - [ ] Visually impaired
   - [ ] Physically impaired
   - [ ] N/A

7. **Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?**
   - [ ] Yes  Explain ____________________________
   - [ ] No

8. **How long have you had diabetes for?**
   - [ ] Years? _________
   - [ ] Months? _________

9. **Have you had diabetes education in the past?**
   - [ ] Yes
   - [ ] No

10. **Has your weight changed over the past year?**
    - [ ] Yes  Lost ________  Gain __________
    - [ ] No

11. **Have you ever tried to change your weight?**
    - [ ] Yes  What have you tried __________________
    - [ ] No

12. **In the past year, which of the below have you done?**
    - [ ] Foot Exam
    - [ ] Dental Exam
    - [ ] Dilated Eye Exam
    - [ ] Lab Work
    - [ ] Complete Physical Exam
    - [ ] Stress Test
    - [ ] Flu Vaccination
    - [ ] Pneumonia Vaccination
    - [ ] Hepatitis B Vaccination
    - [ ] Routine Diabetes Visits
    - [ ] None

13. **Do you monitor your blood sugar?**
    - [ ] Yes
    - [ ] No

14. **What type of Meter do you have?** ________________
    - [ ] none

15. **How often do you check your blood sugar?**
    - [ ] Once a day
    - [ ] 2 or more times per day
    - [ ] Few times a week
    - [ ] Rarely
    - [ ] N/A

16. **What time of day do you check your blood sugar?**
    - [ ] Before Breakfast
    - [ ] 1-2 hours after meals
    - [ ] Bedtime
    - [ ] Random
    - [ ] N/A

17. **Have you ever experienced hyperglycemia (high blood sugar)?**
    - [ ] Yes  Last time ____________
    - [ ] No
    - [ ] Don’t know

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**PLEASE PRINT, COMPLETE & BRING TO YOUR FIRST APPOINTMENT!**
18. Have you ever experience hypoglycemia (low blood sugar)?
   - Yes  Last time ________
   - No
   - Don’t know

19. Do you participate in regular physical activity/exercise?
   - Yes
   - No
   - Sometimes

20. What type of exercise do you do?
   - Biking
   - Walking
   - Running
   - Swimming
   - Tennis
   - Golf
   - Strength/resistance training
   - Stretching
   - Workout videos
   - Other__________________________________
   - None

21. How long do you exercise for?
   - Less than 15 minutes
   - 15-30 minutes
   - 30-45 minutes
   - Greater then 45 minutes
   - N/A

22. Do you have any physical limitation that prevent you from exercising?
   - Yes  Explain_____________________________
   - No

23. Do you carry or wear diabetes identification?
   - Yes
   - No

24. How would you rate your current understanding of Diabetes?
   - Excellent
   - Good
   - Fair
   - Poor

25. How do you feel about having diabetes?
   - Acceptance
   - Adaptation
   - Anger
   - Denial
   - Fear
   - Guilt
   - Overwhelmed/confused
   - Sadness/Depression
   - Other__________________________________

26. How would you rate your overall health?
   - Excellent
   - Good
   - Fair
   - Poor

27. How important is your health to you?
   - Extremely
   - Somewhat
   - Only when sick
   - Not important

28. How do you feel you are managing your diabetes?
   - Excellent
   - Good
   - Fair
   - Poor

29. Do you struggle with making changes in your life to care for your diabetes?
   - Yes
   - Somewhat
   - No

30. Does diabetes interfere with anything in your life?
   - Family/social activities
   - Work/School
   - Sports/Exercise
   - Finances
   - Travel
   - Nothing
   - Other__________________________________

31. Do you feel you have any control over developing diabetes complications?
   - Yes
   - No
   - Maybe

32. How would you rate your stress level?
   - High
   - Medium
   - Low

33. Do you examine your feet?
   - Yes  How often?_____________________  
   - No

34. Do you ever skip or forget to take your medication?
   - Yes  How often________________________
   - No
   - Sometimes
   - N/A

35. Do you have financial resources to care for your diabetes?
   - Yes
   - No
   - Don’t know
36. Do you have emotional resources to care for your diabetes?
   ○ yes  
   ○ No  
   ○ Don’t know

37. Do you follow a meal plan?
   ○ Yes  What kind___________________________
   ○ No

38. How well do you follow your meal plan?
   ○ 100%  
   ○ 75%  
   ○ 50%  
   ○ 25%  
   ○ 0%  
   ○ N/A

39. Have you been told to follow any diet restrictions?
   ○ Low calorie  
   ○ Low carbohydrate  
   ○ Low fat  
   ○ Low cholesterol  
   ○ Low salt/sodium  
   ○ Other___________
   ○ No

40. Are you eating differently since you found out you have diabetes?
   ○ Yes  Explain_____________________________
   ○ No

41. How do you usually decide what to eat?
   ○ Counting calories  
   ○ Counting carbohydrates  
   ○ Avoiding sweets and sugars  
   ○ Avoiding starches  
   ○ Limiting fat  
   ○ Eating anything I want  
   ○ Nothing  
   ○ Other_______________________________

42. How often do you eat in a typical day?
   ○ 1x a day  
   ○ 2x a day  
   ○ 3x a day  
   ○ 4 or more  
   ○ Eat whenever hungry  
   ○ Other_______________________________

43. Do you skip meals?
   ○ Yes  How often or what meal?______________
   ○ No
   ○ sometimes

44. Who does the cooking in your house?
   ○ Self  
   ○ Spouse  
   ○ Other_______________________________

45. Who does the shopping?
   ○ Self  
   ○ Spouse  
   ○ Other_______________________________

46. How often do you eat out?
   ○ Daily  
   ○ 1-3x per week  
   ○ 4-6x per week  
   ○ Occasionally  
   ○ Never

47. How often do you eat sweets or drink sugary drinks?
   ○ Daily  
   ○ 1-2x a week  
   ○ 3-5x a week  
   ○ Sometimes  
   ○ Rarely

48. How often do you eat vegetables?
   ○ 1-3x a week  
   ○ 4-6x a week  
   ○ Daily  
   ○ Rarely

49. How often do you eat fruits?
   ○ 1-3x a week  
   ○ 4-6x a week  
   ○ Daily  
   ○ Rarely

50. Do you have any food allergies or intolerances?
   ○ Yes _________________________________
   ○ No

51. Are you interested in changing the way you eat?
   ○ Yes  
   ○ No  
   ○ Maybe  
   ○ I don’t need too

52. What do you hope to accomplish or gain from this diabetes program?
   ○ Improve blood glucose  
   ○ Improve eating habits  
   ○ Lose weight  
   ○ Feel better  
   ○ Get more information/education  
   ○ Start exercising  
   ○ Lower cholesterol/triglycerides  
   ○ Other_______________________________
   ○ Nothing
53. List 1-2 things you feel you need the most help with to improve your diabetes?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

54. What is the most difficult thing about having diabetes?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

55. List one goal you want to work towards?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
56. Please provide us with your food and beverage intake for the **last 24 hours**? (The more specific the better)

**Breakfast:**
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**Lunch:**
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**Dinner:**
__________________________________________________________________________________________________
__________________________________________________________________________________________________
__________________________________________________________________________________________________

**List ALL Medications: (prescription/over-the-counter and herbal products)**

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<th>Name</th>
<th>Dosage</th>
<th>Frequency (how often)</th>
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