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. Do you have a family history of Diabetes?
   - ☐ Yes who? _____
   - ☐ No

10. Have you had diabetes education in the past?
    - ☐ Yes
    - ☐ No

11. Has your weight changed over the past year?
    - ☐ Yes Lost_____ Gain_____
    - ☐ No

12. Have you ever tried to change your weight?
    - ☐ Yes What have you tried_____
    - ☐ No

13. 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
    - ☐ Routine Diabetes Visits
    - ☐ None

14. Do you monitor your blood sugar?
    - ☐ Yes
    - ☐ No

15. What type of Meter do you have?_____
    - ☐ none

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

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

18. Have you ever experienced 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. What is your current smoking status?
- ☐ Never smoked
- ☐ Current smoker
- ☐ Quit smoking _____

34. Do you examine your feet?
- ☐ Yes How often? _____
- ☐ No

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

36. Do you have financial resources to care for your diabetes?
- ☐ Yes
- ☐ No
- ☐ Don't know

37. Do you have emotional resources to care for your diabetes?
- ☐ Yes
- ☐ No
- ☐ Don't know

38. Do you follow a meal plan?
- ☐ Yes What kind_____
- ☐ No

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 consume alcoholic beverages?
- ☐ Monthly
- ☐ Weekly
- ☐ Daily
- ☐ Rarely

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

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

51. Do you have any food allergies or intolerances?
- ☐ Yes _____
- ☐ No

52. Are you interested in changing the way you eat?
- ☐ Yes
- ☐ No
- ☐ Maybe
- ☐ I don't need too

53. 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

54. List 1-2 things you feel you need the most help with to improve your diabetes?

_____

_____

_____

55. What is the most difficult thing about having diabetes?

_____

_____

_____

56. List one goal you want to work towards?

_____

_____

_____

57. Past Hospitalizations/ ER Visit in the past 5-10 years

_____

_____

_____

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)

Name	**Dosage**	**Frequency (**how often**)**