PLEASE PRINT, COMPLETE & BRING TO YOUR FIRST APPOINTMENT!

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

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)

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