DIABETES SELF MANAGEMENT EDUCATION / NUTRITION COUNSELING
INITIAL ASSESSMENT

NAME_______________________________________ **Today's Date** ____________________________

DATE OF BIRTH ____________________________

CONTACT INFORMATION:

☐ Home Number _______________________ ☐ Cell phone number ___________________________

☐ Work Number _______________________ ☐ Okay to call at work? ☐ No ☐ Yes

Answering machine ☐ No ☐ Yes ☐ Ok to leave message

☐ Your own personal Email Address (Optional) ____

Do you view your email messages at least 3 times per week**?** ☐ No ☐ Yes

Is it ok to communicate information related to your Diabetes via email/voicemail ☐ No ☐ Yes

If yes, please sign: Signature: _______________________________________Date__________________

RACE / ETHNICITY

☐ White / Caucasian ☐ Black / African American ☐ Native American ☐ Middle Eastern

☐ Asian / Chinese / Japanese / Korean / Pacific Islander ☐ Eastern European

☐ Hispanic / Cuban / Mexican / Puerto Rican / Latino

EMPLOYMENT / EDUCATION

Presently Employed ☐ No ☐ Yes ☐ Retired year_______ Type of Work: ☐ sedentary ☐ physical

Occupation: ________________________________ Do you work shifts? ☐ No ☐ Yes ________________

Education: ☐ Some High School ☐ High School Diploma / GED

☐ Some College ☐ Technical School ☐ College Graduate

HEALTH CARE CONCERNS

Do you have financial concerns that may affect your diabetes care? (Foods/Medications) ☐ No ☐ Yes

Who do you live with? ____Number in Household __________

Do you have family, friends or organizations you turn to for support? ☐ No ☐ Yes __________________

Are there any religious or ethnic concerns that may affect your diabetes care? ☐ No ☐ Yes

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DIABETES HISTORY

How many years have you had diabetes? ________ years ☐ Diagnosed within the past year

Type of Diabetes: ☐ type 1 ☐ type 2 ☐ Gestational ☐ Unsure

When do you test your blood sugar? Which meter? ____

☐ I don't test ☐ Before breakfast ☐ Before all meals ☐ Bedtime ☐ 2 hours after a meal

☐ Other ____

Have you had recent episodes of blood sugars over 200 mg/dL ☐ No ☐ Yes

How did you treat this episode? ____

Have you had recent episodes of low blood sugars below 70 mg/dL? ☐ No ☐ Yes

How did you treat this episode? ____

Do you keep a record of blood sugar results in a log book or computer? ☐ No ☐ Yes

MEDICAL HISTORY (CHECK ALL THAT APPLY) ☐ None

☐ Family history of diabetes
☐ High Blood Pressure
☐ Elevated Cholesterol
☐ Sleep Apnea ☐ Asthma
☐ Diabetes during pregnancy
☐ Delivered baby weighing 9 or more pounds
☐ Thyroid Disease ☐ Arthritis
☐ Depression ☐ Emotional Problems

☐ Surgeries / Other ____

____

HEART / STROKE HISTORY: (INDICATE YEAR OF OCCURRENCE) ☐ None

☐ Chest Pain __________ ☐ Heart Attack _________ ☐ Heart Surgery _________

☐ Heart Stents __________ ☐ Heart Failure _________ ☐ Stroke_________

ACUTE/ CHRONIC COMPLICATIONS (CHECK ALL THAT APPLY) ☐ None

☐ Frequent urination
☐ Frequent tiredness
☐ More thirsty than usual
☐ Numbness or tingling in hands/feet
☐ Gastrointestinal problems (constipation, diarrhea, bloating)
☐ Skin problems (dry, scaly, slow healing)
☐ Kidney problems / bladder infections
☐ Pain in legs during or after walking

☐ Eye Problems: ☐ cataracts ☐ macular degeneration ☐ glaucoma ☐ retinopathy

Participant Name: ____

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ALLERGIES

Drug Allergies: ☐ None ______________________________ ☐ Reaction: _________________________

Food Allergies / Intolerances: ☐ None ___________________ ☐ Reaction __________________________

MEDICATIONS: Please answer the questions below or you may bring a list of your medications.

DIABETES MEDICATIONS: Include name, dose, and time(s) of day you take the medication(s).

☐ **None** ____

____

____

OTHER MEDICATIONS: Include name, dose, and time(s) of day you take the medication(s).

____

____

____

____

VITAMINS / SUPPLEMENTS ____

How often do you miss or skip any of your medications? ☐ Sometimes ☐ Rarely/Never

PHYSICAL ACTIVITY

Has your doctor given medical permission for you to exercise? ☐ Yes ☐ No

Has your doctor recommended exercise? ☐ Yes ☐ No

If No, what are your restrictions or limitations? ____

How often do you exercise? Number of times per week _____ Number of minutes each time __________

What kind of exercise do you do? ____

☐ Inactive ☐ Housework / Yardwork ☐ Walking ☐ Strength Training (Weights / Bands) ☐ Gym

HEARING / VISION / WRITING

Do you have any difficulty with written information: ☐ No If Yes: ☐ reading ☐ writing ☐ understanding

Do you have difficulty with hearing? ☐ No ☐ Yes ____

Are there times when you have trouble seeing? ☐ No ☐ Yes ____

Participant Name: ____

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FOOT CARE: How often do you examine your feet? ☐ Daily ☐ Weekly ☐ Rarely

TOBACCO USE

Type: ☐ None ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew / Dip ☐ Other: ___________________________

Packs smoked per day: _______________ Number of years smoked: _________________________________

Are you ready to set a Quit Date? ☐ No ☐ Yes – Quit Date ______________________________________

Do you currently live with anyone who uses tobacco? ☐ No ☐ Yes

I would like assistance with Smoking / Tobacco Cessation? ☐ No ☐ Yes

HEALTH BELIEFS	**Agree**	**Neutral**	**Disagree**
My health is important to me.	☐	☐	☐
Diabetes interferes with daily activities.	☐	☐	☐
I am afraid I will get complications.	☐	☐	☐
I have accepted my diagnosis of diabetes.	☐	☐	☐
I have control over how my diabetes is managed.	☐	☐	☐

How would you describe diabetes? ____

____

DIABETES EDUCATION

Have you had any Diabetes Education in the past? ☐ No ☐ Yes If yes, did you meet with a

☐ Diabetes Nurse Educator? ☐ Registered Dietitian? ☐ Physician Office Staff

Have you attended Diabetes Classes? ☐ No ☐ Yes If yes, location _________________________________

How would you rate your understanding of diabetes? ☐ Good ☐ Fair ☐ Poor

HOSPITALIZATIONS

Have you been seen in the Emergency Room in the last 12 month? ☐ No ☐ Yes

Reason: ____

Have you been hospitalized in the last 12 months? ☐ No ☐ Yes

Reason: ____

Participant Name: ____

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HEALTH SYSTEM

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STANDARDS OF CARE FOR DIABETES

When was the last time you had the following health services?

	Within Last 6 months	Within Last Year	2 or More Years Ago	Don't Know/Never
Physical Exam	☐	☐	☐	☐
Dental Exam	☐	☐	☐	☐
Dilated Eye Exam	☐	☐	☐	☐
Foot Exam	☐	☐	☐	☐
Flu Vaccine	☐	☐	☐	☐
Pneumonia Vaccine	☐	☐	☐	☐
Urine Test for Protein	☐	☐	☐	☐
A1C Blood Test	☐	☐	☐	☐
Cholesterol Blood Test	☐	☐	☐	☐
Review of Glucose Meter	☐	☐	☐	☐
Review of Insulin Injection	☐	☐	☐	☐

ALCOHOL USE:

☐ Never ☐ Daily ☐ Occasionally ☐ Weekly ☐ I have a problem with alcohol.

Number of Drinks per day ___________ per week __________ per month ____________________

Type of Alcohol: ____

PREGNANCY, IF APPLICABLE

Pre-pregnancy weight ________ Last Menstrual Period ___________ Number of weeks pregnant _______

Expected Due Date: __________ Where do you plan to deliver your baby? _________________________

Do you plan to breastfeed your baby? ☐ Yes ☐ No ☐ Unsure

Did you smoke prior to your pregnancy? ☐ Yes ☐ No ☐ Never

Participant Name: ____

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In your own words, why are you seeing the Dietitian? ____

Explain any previous diet education ____

EATING HABITS: Typical Meal Pattern

☐ Breakfast, Lunch, Dinner ☐ 2 meals / day ☐ No set pattern ☐ Eat whenever I am hungry

Snack Time(s): ☐ None ☐ Between Meals ☐ Bedtime ☐ Eat throughout the day

Do you skip Meals? ☐ No ☐ Yes ----- ☐ Daily ☐ Weekly ☐ Infrequently.

Smoothies/ Health Shakes/ Supplemental Drink use: ____

Number of meals eaten in **restaurants** per week is: _______Type is mostly: ☐ fast food ☐ *not* fast food

Who plans or prepares meals? ☐ Self ☐ Spouse ☐ Other ______________________________________

HOW OFTEN DO YOU EAT THE FOOD GROUPS LISTED BELOW?

Select one: Never = 0 Occasionally =1 Daily =2 Several times a day =3

Fruits: _____ Vegetables: ____ Meat, fish, chicken, cheese, other Protein foods, etc: _____

Starchy foods, such as bread, cereal, pasta, beans, cracker, etc. _____ Milk, yogurt: _____

Fatty foods, fried foods, gravy, salad dressing: ____ Sweetened beverages/soda pop: _____

Sugar, Honey, Cookies, ice cream, desserts, sweets: _____

How would you rate your **portion** control: ☐ I eat too little ☐ Just Right ☐ I eat too much

WEIGHT HISTORY:

Highest weight _______ in what year? _________ Lowest weight_______ in what year?___________

Over the past year, has your weight changed? ☐ Gained or ☐ Lost - How much? ________ pounds

Current Height__________ Weight__________ Goal Weight____________

READINESS TO CHANGE:

Your past **success rate** at changing your behaviors for the better is: ☐ poor ☐ fair ☐ good ☐ very good

Rate the "Readiness" you now have to change your eating behaviors:

Circle one: none =1 low =3 moderate =5 high =7 very high = 9-10

Rate the "Readiness" you now have to change your activity level:

Circle one: none =1 low =3 moderate =5 high =7 very high = 9-10

*Bring a 3 day record of your food & beverage intake; include time of day and amounts.

Participant Name: ____