

Assessment

Today's Date: _____

Name: _____ Preferred Name: _____ Date of Birth: _____

Lifestyle/Coping and Health Assessment

Primary Language: English Spanish French Other _____

Race/Ethnicity: Black African American Hispanic American Indian or Alaskan Native Middle Eastern Asian/Pacific Islander White/Caucasian Other: _____

Please list cultural or religious beliefs that may impact your care: _____

Marital Status: Single Married Divorced Widowed

Who else lives in your household? _____

Do you work? Yes No What do you do for work? _____ Work hours? _____

What is the last grade you completed in school: _____

Do you have any learning disabilities (such as dyslexia) or problems with vision, hearing, or reading? Please explain: _____

Have you had Diabetes Education before? Yes No If yes, where and when? _____

Have you met with a Dietitian before? Yes No If yes, where and when? _____

How do you prefer to learn? Listening Reading Demonstration Doing Group Session No learning preference Other: _____

Tobacco Use? Yes No What type of tobacco product? _____ How much per day? _____

Alcohol Use? Yes No How many alcoholic beverages per week? _____

General Diabetes Information

What type of Diabetes do you have? Type 2 Type 1 Other: _____

When were you diagnosed with Diabetes? _____

How often do you check your blood sugar? _____

When do you check your blood sugar? Before meals 2 hours after meals Bedtime

What is the name of your blood sugar machine? _____

What was your last Hemoglobin A1c? _____ Date of last A1c: _____

In the last 7 days, what was your lowest and highest blood sugar? Lowest: _____ Highest: _____

Do you take Diabetes medication? Yes No If yes, write the name of the Diabetes medication(s), the dose, and how often you take it: _____

Diabetes Stress and Support

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

Who else in your family has Diabetes? _____

List anything about Diabetes that causes you stress or distress: _____

How do you deal with this stress/distress? _____

Who is your main support person? _____

Nutrition and Physical Activity

What is your biggest challenge when it comes to food? _____

Do you tend to skip meals? Yes No If yes, which do you skip: Breakfast Lunch Dinner

If you have food allergies, please list them: _____

Please list all the beverages you usually drink: _____

How many times a week do you dine out? ≥ 8 times 5-7 times 3-5 times 2-3 times 1-2 times

Do you exercise? Yes No If yes, how often and what type of exercise? _____

What (if any) challenges do you have concerning physical activity? _____

Medical History

Eye problems: Yes No Specify: _____
Numbness/tingling/loss of feeling in your feet: Yes No Specify: _____
Kidney problems: Yes No Specify: _____
Stomach or bowel problems: Yes No Specify: _____
Sexual problems: Yes No Specify: _____
Frequent infections (getting infections pretty often): Yes No Specify location: _____
Heart problems such as high blood pressure or stroke: Yes No Specify: _____
Lung/breathing problems: Yes No Specify: _____
Dental problems: Yes No Specify: _____

Chronic Complications

Do you have a primary care doctor? Yes No Date of last visit: _____
Do you examine your feet daily? Yes No
Do you see a Podiatrist (a foot doctor)? Yes No Date of last visit: _____
Do you see a Dentist? Yes No Date of last visit: _____
Do you see an eye doctor? Yes No Date of last visit: _____
Did you get the flu vaccine? Yes No Date: _____
Did you get the shingles vaccine? Yes No Date: _____
Did you get the COVID-19 vaccine? Yes No Date: _____

Acute Complications

Do you ever have a blood sugar of 350 or more? Yes No How often: _____
Do you ever have *hypoglycemia*? (blood sugar below 70)? Yes No How often: _____
If you do get blood sugars below 70, when does it usually happen? _____
How do you treat *hypoglycemia*? _____
Have you ever had DKA (Diabetic Ketoacidosis)? Yes No When: _____
Do you ever test for ketones? Yes No What would you do if you have ketones? _____
How do you manage your Diabetes when you are sick? _____

Over the past two weeks, how often have you been bothered by any of the following problems? Please choose an appropriate response for each item:

- Little interest or pleasure in doing things
Not at all Several days More than ½ the days Nearly every day
- Feeling down, depressed, or hopeless
Not at all Several days More than ½ the days Nearly every day
- Feeling bad about yourself or that you are a failure, or have let yourself or your family down
Not at all Several days More than ½ the days Nearly every day
- Thoughts that you would be better off dead or hurting yourself in some way
Not at all Several days More than ½ the days Nearly every day

I am ready to make changes to better manage by Diabetes: 1 2 3 4 5
Not ready-----Very Ready

Diabetes Treatment Center Staff Only: signature indicates completion of face-to-face assessment

Reviewer’s signature/title and date: _____

Name: _____

Pre-Test

1. Diabetes is diagnosed by:
 - a. A fasting blood sugar of 126 or higher
 - b. A weight gain of 10-15 pounds
 - c. A high blood pressure diagnosis
2. Which of the following foods turn into sugar in the blood:
 - a. Carbohydrate
 - b. Protein
 - c. Fat
 - d. All of the above
3. The usual treatment for people with diabetes includes:
 - a. Meal planning, exercise, and medication
 - b. Exercise only
 - c. Medication only
4. The most common symptoms of *Hypoglycemia* are:
 - a. Sweaty, shaky, dizzy, irritable
 - b. Thirsty, frequent urination, tired, blurred vision
5. The best treatments for *Hypoglycemia* are:
 - a. ½ cup juice, ½ cup regular soda, 3 glucose tablets, 4 glucose tablets, or 1 Tbsp honey
 - b. Chocolate candy bar
 - c. Diet soda
6. Diabetes can cause changes in blood vessels that harm blood-flow to the eyes, so it is important to have a yearly dilated eye exam to check for any problems and help protect your vision.
 - a. True
 - b. False
7. Drinking water and exercising can help lower a high blood sugar.
 - a. True
 - b. False
8. A good range for fasting blood sugar is:
 - a. 50-70
 - b. 80-130
 - c. Less than 200
9. Getting enough sleep, reducing stress, exercising, and eating healthy can all help people with diabetes maintain good blood sugar levels.
 - a. True
 - b. False
10. Which of the following foods does not raise blood sugar?
 - a. Chicken breast
 - b. Baked potato
 - c. Yogurt