



Initial Assessment

(Please complete front and back of this form)

Date: _____

Visit type: **Class**

Demographics:

Name: _____

Date of Birth: _____

Age: _____

Doctor: _____

Current occupation and work hours/shifts: _____

Who lives with you? _____ Who is your main support person? _____

When you were diagnosed with diabetes? _____ Type of diabetes: Type I Type II Pre-diabetes

Meal Planning, Nutrition and Exercise:

Height: _____ Weight: _____ Recent weight loss/gain: _____

What has been your lowest body weight in the last ten years? _____

What do you consider to be a healthy weight for yourself? _____

Have you ever been given a meal plan, if so how many calories? _____

Do you currently have a meal plan for your diabetes? _____

Have you followed any meal plan program before? Is so, what program and when. _____

Current meal restrictions/religious limitations/allergies: _____

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

Who does your grocery shopping/cooking? _____

How many times each week do you eat out? _____

Do you exercise? What type and how often? _____

Monitoring and Self-Care:

How often do you check blood sugars? Never 2-3 times/week 1 time each day 2-3 times/day

When do you check your blood sugar: _____

Do you have your own blood sugar machine? What kind? _____

What is your blood sugar range: _____ to _____

Blood sugar readings: Fasting _____ Other _____

Do you ever have blood sugar readings higher than 200? How often? _____

Do you ever have blood sugar readings lower than 70? How often? _____

Do you understand how to manage diabetes when you are sick? _____

Have you been admitted to the hospital because of diabetes? _____

If yes, when? _____

General Health:

Health conditions, other than diabetes, please circle:

High Blood Pressure

High Cholesterol

High Triglycerides

Obesity

Stroke

Heart Disease

Kidney Disease

Sleep Apnea

Arthritis

Thyroid Disease

Depression

Gastroparesis

Amputation

Eye Disease

Dental Disease

Stomach or Bowel Problems

Osteoporosis

Allergies

Frequent Infections

Other: _____

Do you smoke? _____ How many packs per day? _____ For how long? _____

Have you ever tried to quit smoking? _____

Do you drink alcohol? _____ Type of alcohol, if so? _____ How often? _____

✓ (please turn over to complete page 2)

Do you have any of the following health problems caused by diabetes? If yes, please circle:

- | | |
|--|------------------|
| Numbness/tingling/loss of feeling in your feet | Kidney Problems |
| Eye Problems | Dental Problems |
| High Blood Pressure | High Cholesterol |
| Sexual Problems | Gastroparesis |

Monitoring:

- Do you check your feet daily? Yes No
Had a foot exam by a physician? Yes No If yes, date: _____
Have you had a dilated eye exam? Yes No If yes, date: _____
Received a flu shot and/or pneumonia vaccine in past 12 months? Yes No
How often do you go to the dentist? _____
Please provide most recent A1c% result and date. _____ N/A
Please provide most recent cholesterol result and date. _____ N/A
Please provide most recent blood pressure result and date. _____ N/A

Medications:

- List any allergies to medications: _____
Do you take diabetes medications? Yes No
Please check all that apply and list doses and how often you take the medication.
 Diabetes Pills _____
 Byetta/Bydureon/Victoza/Tanzeum/Symlin _____
Insulin shots _____
Inhaled insulin _____
If on insulin, method of administration: Pen Pump Syringe

List **all** medications that you are currently taking.
List doses, how often, and when you take them.
(Including insulin, water pills, vitamins/herbal supplements)

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

Learning needs/goals:

- Have you ever seen a dietitian or diabetes educator? Yes No When? _____
What is the last grade completed in school? _____
Do you have any learning disabilities (dyslexia) or problems with vision, hearing, or reading? Please explain:

Additional Information:

- Does diabetes cause other problems for you? If yes, in which areas?
Finances Depression Insurance Relationships Problems at work
Other _____
What concerns you most about diabetes? _____
What is the hardest for you in caring for diabetes? _____
How do you handle things that worry you? _____

I am ready to make changes to my lifestyle for better blood sugar control.

1 2 3 4 5
Not-----Very

Diabetes Treatment Center Staff: *signature indicates completion of assessment*

Signature/title: _____ Date _____