DIABETES TREATMENT CENTER

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: _____

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

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: First thing in the morning / Before meals / After meals / Before bed

What is the name of your blood sugar machine? _____

What is your blood sugar range: _____

Blood sugar readings: Fasting _____ Other_____

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

Have you ever been admitted to the hospital because of acute diabetic complications, such as Diabetic Ketoacidosis or high/low blood sugar? _____ If yes, when? _____

Have you had any recent blood sugars over 200? _____

Have you had any recent blood sugars under 70? _____

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	Hyper/Hypothyroid Disease	Depression/Anxiety	Gastroparesis
Amputation	Eye Disease	Dental Disease	History of Cancer
Stomach or Bowel Problems	Osteoporosis	Allergies	Gout
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? Yes / No 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 (slow gastric emptying)

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. _____

Medications:

Medication Allergies?: _____
Do you take diabetes medications? □ Yes □ No

Please check all that apply and list doses and how often you take the medication.

- **Diabetes Pills**: (Metformin, Glipizide, Glimepiride, Januvia, Janumet, Farxiga, Invokana, Jardiance, Actos, Kombiglyze, Xigduo, Other)
  _____

□

- **Non-Insulin Injection:** (Byetta, Bydureon, Saxenda, Victoza, Tanzeum, Symlin, Trulicity, Ozempic)
  _____
- **Insulin Injection**: (Lantus, Levemir, Tresiba, Toujeo, Novolog, Humalog, 70/30 Mix, NPH, Other)
  _____
  *Method of administration: (Circle) □ Pen □ Pump □Syringe
- Inhaled insulin (Afrezza):
  _____

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? _____

How do you handle things that worry you (Stress)? _____

I am ready to make changes to my lifestyle for better blood sugar control. 1 2 3 4 5
Not ready----------Very ready

Diabetes Treatment Center Staff: *signature indicates completion of assessment*
Signature/title: _____ Date _____