DCH Diabetes and Nutrition Education Center

Participant Assessment of Diabetes Self-Management

Name: _____Date: _____

When is your next appointment with your doctor? _____
Date of Birth: ___/___/___ Age: _____ Gender: F□ M□ Ht _____Wt _____
Marital Status: Single□ Married□ Divorced□ Widowed□
Ethnic Background: White/Caucasian□ Black/A-A□ Hispanic□
Native American□ Middle-eastern□ Other□_____
What is your language preference? English□ Other □_____
Visitor Attending _____ Relationship_____

1. What type of diabetes do you have? Type 1□ Type 2□ Pre-diabetes□ Don't Know□
2. How long have you had Diabetes? _____
   List relatives with diabetes: _____
3. In your own words, what is diabetes? _____
4. Have you had previous instruction on how to take care of your diabetes? Y□ N□
   If yes, how long ago: _____ Where _____

5. Do you take diabetes medications? Y□ (check all that apply below) N□
   Diabetes pills□ List:_____
   _____
   Insulin □ List: _____
   _____
   About how often do you miss taking your medication as prescribed? _____
6. Do you take **other medications**? Y□ N□ Please list other medications: _____
   _____ _____
   _____ _____
   _____ _____
7. Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? Y□ N□ Please describe_____

8. Please state whether you agree, are neutral or disagree with the following statements:
   I feel good about my **general health**: agree□ neutral□ disagree□
   My diabetes interferes with other aspects of my life: agree□ neutral□ disagree□
   My level of **stress** is: low□ moderate□ high□
   I have some control over whether I get diabetes complications or not:
   agree□ neutral□ disagree□
   I feel ready to make changes in my life to care for my diabetes:
   agree□ neutral□ disagree□
9. What concerns you most about your diabetes? _____
   _____
10. What is hardest for you in caring for your diabetes? _____

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11. From whom do you get support for your diabetes? Family□_____
    Co-workers □ Healthcare providers□ Support group□ No-one□
12. How do you handle stress? _____
13. What are your thoughts or feelings about having diabetes (e.g., denial, frustrated, angry, guilty, acceptance)? _____
    _____
14. What are you most interested in learning from these diabetes education sessions? _____
    _____
15. Do you **check your blood sugars**? Y□ N□ Blood sugar range: _____ to _____
    How often: Once a day□ 2 or more per day□ 1 or more per Week□ Occasionally□
    When do you check your blood sugar?
    Before breakfast□ 2 hours after meals□ before bedtime□
    Do you have a **meter**? Y□ N□ Name of meter: _____
    How old is your meter? _____
    What is your **target blood sugar range**? _____
16. In the last month, how often have you had a low blood sugar reaction?
    Never□ Once□ One or more_____ times per week□
    What are your symptoms? _____
    How do you treat your low blood sugar?_____
17. Can you tell when your blood sugar is too high? Y□ N□
    What do you do when your sugar is high?_____

18. Check any of the following **tests/procedures** you have had in the last 12 months:
    dilated eye exam □ urine test for protein□ foot exam □ dental exam□
    HgA1c□ flu shot□ pneumonia shot□ sleep study□
    blood pressure□ cholesterol□ weight□

19. In the last 12 months, have you?
    used emergency room services: Y□ N□ been admitted to a hospital: Y□ N□
    Was emergency room visit or hospital admission diabetes related? Y□ N□
20. Do you have any of the following? eye problems□ kidney problems□ depression□
    numbness/tingling/loss of feeling in your feet□ dental problems□ sexual problems□
    high cholesterol□ high blood pressure□ overweight□ sleep apnea□ stroke□
    heart disease□ heart attack□ angioplasty□ stent□
    If yes, explain _____
    Other health problems: _____
    Surgeries: _____

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21. Mark your **risk factors** for heart disease: high blood pressure□ smoking□
    high cholesterol or triglycerides□ overweight□ high stress□
    Existing heart disease□ family history of heart disease□ low exercise□
22. Do you drink alcohol? Y□ N□ What type: _____
    How many drinks _____ per day□ per week□ occasionally□
23. Do you use tobacco: cigarette□ pipe□ cigar□ chewing□ none□
    quit□--how long ago _____ how much_____
24. Do you **exercise** regularly? Y□ N□
    What type: _____ How Often: _____
    I plan to: maintain□ increase□ my level of activity.

25. How do you learn best? Listening□ Reading□ Observing□ Doing□
26. Do you have any difficulty with? hearing□ seeing□ reading□ speaking□
    Explain any checked: _____
27. Do you use computers? Y□ N□: to email□ look for health and other information□
    Do you have an email address? Y□ N□ Can we use your email address to send you
    Information, if necessary? Y□ N□ What is your email address? _____
28. What is the last grade of school you have completed? _____

29. Are you currently employed? Y□ N□ What is your occupation? _____
30. Are you retired? Y□ N□

31. How many people live in your household? _____
    How are they related to you? _____

Please do not write below this line

CLINICIAN ASSESSMENT SUMMARY: _____
_____
_____
_____
_____

Education Needs/Education Plan: Diabetes disease process; Nutritional Management; Physical Activity; Using Medications; Monitoring; Preventing Acute Complications; Preventing Chronic Complications; Behavior Change Strategies; Risk Reduction Strategies; Psychosocial Adjustments

Date: _____ Clinician Signature: _____

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Do you have a meal plan for diabetes? Y□ N□ If yes, please describe: _____
_____

How often do you use this meal plan? Never□ Seldom□ Sometimes□ Usually□ Always□
Do you read and use food labels as a dietary guide? Y□ N□
Do you have any diet restrictions? Salt□ Fat□ Fluid□ Carbohydrate□
None□ Other□ _____

Give a sample of your meals for the last 24 hours including drinks:

Breakfast Time: _____ Food/Drink: _____
_____
_____
_____

Snack Time: _____ Food/Drink:_____
_____

Lunch Time: _____ Food/Drink: _____
_____
_____
_____

Snack Time: _____ Food/Drink: _____
_____

Dinner Time: _____ Food/Drink: _____
_____
_____
_____

Snack Time: _____ Food/Drink: _____
_____

Do you do your own food shopping? Y□ N□, If not, who does? _____
Do you cook your own meals? Y□ N□, If not, who does? _____
How often do you eat out? _____
Are you interested in? Losing weight□ gaining weight□ maintaining present weight□