Initial Assessment

Date: _____ Date of Birth: _____ Gender: Male or Female

Full Name _____

Street Address _____

City_____ State _____ Zip Code _____ Email_____

Best Phone # to reach you: _____ which phone is this: Home • Cell • Work

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

Occupation_____

Preferred Language (circle one): English ••• Spanish ••• Other _____

Education (highest level completed) ☐8th Grade or less ☐Some High School ☐High School Graduate /GED
☐Some College ☐College Degree (BA/BS) ☐Graduate Degree ☐Doctorate Degree

When were you diagnosed with diabetes? _____

Circle the type of diabetes do you have Type 1 •• Type 2 •• Gestational •• Pre-diabètes •• Not Sure

Do you check your blood sugar? No • Yes _____ times a day.

In the past week, how many days did you test you blood sugar (circle your answer) 0 •• 1 •• 2 •• 3 •• 4 •• 5 •• 6 •• 7

Blood Sugar Meter Brand and Name: _____

Times you check your blood sugars _____

Usual blood sugar range AM_____ PM _____ 1-2 hours after meals _____

Do you test your Urine Ketones? No •Yes -whenften_____

I have high blood sugars of _____how often _____

My high blood sugar symptoms are _____

I have low blood sugars of _____how often _____

My low blood sugar symptoms are _____

Circle the items you cannot afford: Food••Housing••Transportation••Utilities••Medications••Diabetes Supplies

Circle the item you have issues with: Seeing ••• Hearing ••• Writing ••• Reading ••• Standing ••• Sitting•••Walking

Do you have constant pain: No ••• Yes – where: _____

How long have you had this pain? _____ Treatment you have received for this pain: _____

Circle your general feelings about your overall health: very healthy •somewhat healthy• not very healthy • unhealthy

Circle the medical conditions you have or have had.

Depression	Anxiety	Coronary Artery Disease	Heart Disease	Heart Attack
HIV or AIDs	Amputations	High Cholesterol	High Blood Pressure	Nerve Pain (Neuropathy)
TIAs	Cataracts	Diabetes Eye Disease	Protein or Albumin in your Urine	
Kidney Disease	on Dialysis	Kidney Transplant		

Other health concerns:_____

List any allergies you have:_____

Stressors in your life and how you manage them: _____

_____

Fallen in the past month: No •• Yes - _____ times. Describe how you fell and any injuries from the falls: ____

_____

Do you use tobacco products: No •• Yes – What type and how often: _____

If you have ever tried to quit, how: _____

Do you drink alcohol: No •• Yes – What type, how much, how often: _____

Do you or have you had addictions No •• Yes – to _____

Over the past two weeks, circle how often have you been bothered by any of the following problems?

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

Home Life: Do you feel safe in your home Yes •• No - _____

Who lives in your home? _____

Who does the grocery shopping? _____ where _____

Who cooks? _____

Are you eating differently since you were diagnosed with diabetes? No •• Yes – how: _____

Circle the meals you eat each day: Breakfast •• Lunch •• Dinner How many snacks do you eat a day? _____

How many days a week do you eat out and which meals? _____

In the past week how many days did you eat 3 or more servings of vegetables other than corn, peas, or potatoes?

(circle your answer) 0 •••• 1 •••• 2 •••• 3 •••• 4 •••• 5 •••• 6 •••• 7

List any special dietary needs? _____

Does your culture or religion require fasting or dietary restrictions? No •• Yes – explain: _____

Do you exercise? No ••Yes – what type? ____

How many days a week do you exercise? (circle your answer) 0 •• ••1 •••• 2 •••• 3 •••• 4 •••• 5 •••• 6 •••• 7

How many days a week do you check your feet for sores, cracks, wounds, blisters, etc.?

(circle your answer) 0 •••• 1 •••• 2 •••• 3 •••• 4 •••• 5 •••• 6 •••• 7

Are you experiencing any sexual problems? No •• Yes – explain ____

Have you sought treatment for this? No •• Yes – explain ____

Last blood pressure reading? _______/_________ date: _____________________ by whom: ____________________

When was your last dental exam? ________________ When was your last dental exam? _______________________

When was you last eye exam? _____________________

Most recent: Blood Pressure ______/________ date _________ A1C: _________% date ___________________

Total Cholesterol _______ HDL ________ LDL ________ Triglycerides _________ date _______________

Flu vaccination (date) _______________________ Pneumonia vaccination (date) ________________

Date of your last primary care appointment: ____

Date of your last foot exam by a healthcare provider? ______________________________________

List any specialists you have seen in the past 12 months: ______________________________________

____

In the past 12 months?

Have you been in the hospital? No •• Yes – due to a high or low blood sugar? N •• Y - __________ times

Reason in hospital: ____

Have you been in the emergency room? No •• Yes – due to high or low blood sugar? N•• Y - ________ times

Reason in the ER: ____

What is your Height: ______________ Weight: _________# - What do you want to weigh?: _____________#

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Women Only

Have you ever had Gestational Diabetes? No •• Yes – How many pregnancies and when? ________________________

# of Pregnancies: ___________ # of live births? ___________ #of babies weighing 9# or more at birth? ______________

Are you using birth control: No ••Yes – type ____

Are you pregnant? No •• Yes – due date: ________________ Planning to get pregnant? No •• Yes – when __________
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Diabetes and You

Have you had diabetes education? No •• Yes – when/where: _____

How confident are you that you can manage your diabetes?

(circle your answer) 0 •••• 1 •••• 2 •••• 3 •••• 4

(0= not confident at all and 4 = full confident)

How well do you feel you understand your diabetes?

(circle your answer) 0 •••• 1 •••• 2 •••• 3 •••• 4

(0 = do not understand at all and 4 = fully understand)

In the past week, how may days did you take your diabetes medications as prescribed by your doctor?

(circle your answer) 0 •••• 1 •••• 2 •••• 3 •••• 4 •••• 5 •••• 6 •••• 7

Who helps you with your diabetes? _____

What do you hope to gain from DAN's diabetes series? _____

_____

What two things do you feel you need the most help with to improve your diabetes?

1. _____
2. _____

Medications:

List or attach a list of all the medications (prescribed or over the counter), vitamins, herbs and supplements you take.

NAME	**DOSE** (# mg)	**FREQUENCY** (how often)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reviewed by: _____ Date:_____