Self-Management Assessment

Please fill out the enclosed forms and bring to the front office secretary at the time of your first visit. The diabetes educators use these forms to work with you to create an individualized treatment plan.

If you have difficulty filling out this form, please let us know if any of the following problems exist:

____ Seeing ____ Hearing ____ Reading ____ Writing

Please complete all 4 pages of this packet (**Note**: Pages are double sided)

Please remember to sign the last page.

We appreciate the opportunity to serve you better with the use of this completed form. The staff at Diabetes and Endocrinology Associates, P.C. looks forward to working with you.

Self-Management Assessment

Name: ________________________________ DOB:_______________ Date: _____________

Nutrition History

- **Are you following, or have your ever followed any type of meal plan or diet, such as exchange lists, calorie counting, carbohydrate counting, low cholesterol, low fat, low sodium, or an extreme diet (such as fasting, or a fad diet)?** ☐ yes ☐ no
  - If yes, please describe ………………………………………………………………...
- **How many people live in your household?** …………… **Ages**: …………………………..
- **Who usually does the food shopping in your household?** …………………………
- **Who usually does the cooking in your household?** ………………………………..
- **How many times per week do you eat away from your home?** ………………………..
- **Do you keep food records?** ☐ yes ☐ no
- **Do you drink alcohol?** ☐ yes ☐ no
  - If yes, how often? ………………………………
- **Do you take vitamins, minerals, herbs, or any other food or nutritional supplement?** ☐ yes ☐ no
  - If yes, please list ……………………………………………………………………
- **Do you regularly eat three meals per day?** ☐ yes ☐ no
  - If no, please describe …………………………………………………………………

Physical Activity History

- **Do you exercise regularly (examples include walking, dancing, biking, aerobics)?** ☐ yes ☐ no
  - If yes, please describe what type of exercise and how much time each week you spend doing the exercise …..
    ……………………………………………………………………………………
    ……………………………………………………………………………………
- **Do you perform other activities of daily living such as housework, gardening, or climbing stairs?** ☐ yes ☐ no
  - If yes, please list ……………………………………………………………………

Weight history

- **Height** ………………. **Current Weight** ……………. **Usual weight** …………………..
- **Has your weight changed over the past year?** ☐ yes ☐ no
  - If yes, please describe how ………………………………………………………...
- **What do you consider to be a healthy weight for you?** …………………………………..
- **Have you ever tried to change your weight before?** ☐ yes ☐ no
  - If yes, please describe and discuss your success ……………………………………...
    ……………………………………………………………………………………

Name: ________________________________ DOB:_______________ Date: _____________

Stress and Support History

- **Have you had a significant change in life events (such as marriage, divorce, death in the family, new home, or a change in employment) over the past year?** ☐ yes ☐ no
  - If yes, please describe …………………………………………………………………...
- **How does stress affect you physically or emotionally (such as headaches, sleeping difficulties, eating too much or too little, fear, depression)** ……………………………….
  …………………………………………………………………………………………………
- **How do you deal with stress?** …………………………………………………………...
- **From whom do you get support for your diabetes and other stressors?** ☐ family ☐ friends ☐ co-workers ☐ spirituality ☐ culture ☐ health care providers ☐ other.………..

Diabetes Knowledge

- **In your own words, what is diabetes?** …………………………………………….………
  …………………………………………………………………………………………………
  …………………………………………………………………………………………………
- **Are you aware of any potential long-term affects of diabetes?** ☐ yes ☐ no
  - If yes, please describe …………………………………………………………………...
- **Have you ever received information about the following topics?** (Please check all that apply) ☐ blood sugar testing ☐ high blood sugar ☐ low blood sugar ☐ sick day care ☐ insulin ☐ diabetes medications ☐ pregnancy and diabetes ☐ diabetes complications ☐ exercise ☐ hygiene ☐ behavior change ☐ meal planning

What are you interested in learning from these diabetes education sessions? ………..
…………………………………………………………………………………………………
……………………………………………………………………………………………

Health Beliefs and Cultural Influences

- **Do you observe any cultural or religious beliefs that may influence your diabetes treatment and/or meal plan?** ☐ yes ☐ no
  - If yes, please describe …………………………………………………………………...
- **Do you frequently consume ethnic foods?** ☐ yes ☐ no
  - If yes, please describe ....

What is the highest level of education you have completed? ……………..……………...

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Diabetes Management and Record Keeping

- **What type of diabetes do you have?** ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes ☐ Don't know
- **Do you have any relatives with diabetes?** ☐ yes ☐ no
  - If yes, please list …………………………………………………………………………
- **Have you had previous instructions on how to take care of you diabetes?**

  ☐ yes ☐ no
  - If yes, please describe ……………………………………………………………………...
- **What concerns you most about diabetes?** …………………………………………………
- **What is hardest for you in caring for your diabetes?** …………………………..…………

  ………………………………………………………………………………………………
  - What are your thoughts and feelings about this issue? (such as frustration, anger, guilt) …

    ………………………………………………………………………………………………
- **What do you do differently to take care of your diabetes?** ……………………………...

  ………………………………………………………………………………………………
- **Do you take medication for your diabetes?** ☐ yes ☐ no
  - If yes, please check all that apply ☐ Insulin injections ☐ Pills ☐ Byetta injections

    ☐ Symlin injections
  - Do you know if there are side effects for your medications? ☐ yes ☐ no
    - If yes, please describe ………………………………………………………………...
- **What is your target blood sugar range?** ....
- **Do you check your blood sugars?** ☐ yes ☐ no
  - If yes, how often? ………………………………………………………………………..
  - If yes, when do you check your blood sugars? ……………………………………………
- **Do you keep blood sugar records?** ☐ yes ☐ no
  - If yes, how often? ………………………
- **In the last month, how often have you had a low blood sugar reaction?**

  ☐ Never ☐ Once ☐ One or more times per week
  - When you have a low blood sugar, what are your symptoms? ……………………….......

    ………………………………………………………………………………………………
  - How do you treat a low blood sugar? ……………………………………………………...

    ………………………………………………………………………………………………
- **Can you tell when your blood sugar is too high?** ☐ yes ☐ no
  - What do you do when your blood sugar is high? …………………………………………..
- **Do you keep any other kinds of records (such as blood pressure)?** ☐ yes ☐ no
  - If yes, please describe ……………………………………………………………………

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Lifestyle Changes

- **Have you made any changes in your lifestyle that you feel good about?** ☐ yes ☐ no
  - If yes, what? ……………………………………………………………………………..
- **What barriers have kept you from making changes in the past?** …………...………….. ………………………………………………………………………………………………
- **What information would you like from the dietitian?** (Please check all that apply)

  ☐ meal planning ☐ eating out ☐ eating less fat

  ☐ weight management ☐ exercise ☐ record keeping

  ☐ food label reading/supermarket shopping ☐ other ………………………..
- **What changes would you like to make?** (Please check all that apply)

  ☐ Improve my eating habits ☐ Improve my activity level ☐ Lower my blood pressure

  ☐ Manage my weight ☐ Improve my energy level ☐ Control my food cravings ☐ Improve my blood glucose control ☐ Improve my cholesterol, triglyceride levels ☐ Prevent high or low blood sugar levels ☐ Feel better about my health ☐ Other …………………….

Health Care Utilization

- **Do you use tobacco?** ☐Cigarette ☐pipe ☐cigar ☐chewing ☐quit ☐Never used
- **Have you had a dilated eye exam within the last year?** ☐ yes ☐ no
  - If yes, when (month/year)? ……………….……………..
- **Have you been to the emergency room in the past 3 months because of your diabetes?** ☐ yes ☐ no
  - If you have been for other reasons, please list ……………………………………………
- **Do you inspect your feet at least one time per week?** ☐ yes ☐ no
- **Do you have any of the following (please check all that apply)?**

  ☐ eye problems ☐ kidney problems ☐ numbness/tingling/loss of feeling in your feet

  ☐ dental problems ☐ high blood pressure ☐ high cholesterol ☐ sexual problems

  ☐ depression

Your Signature: ______________________________
Date: _______________________

Name: _________________________________ DOB:_______________ Date: _____________

Please do not write below this line

Education Plan includes: Diabetes disease process, Nutritional management, Physical Activity, BG Monitoring, Preventing Acute Complications, Preventing Chronic Complications, Behavior Change Strategies, Risk Reduction Strategies and Psychosocial adjustment

Educator Assessment Notes

____
____
____
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Educator's Signature: ______________________________