Diabetes Self-Management Initial Assessment Form

Date: ___________________

Name (Last, First, MI):____Date of Birth: ____________________________

MEDICAL HISTORY

☐ Prediabetes ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other____________________ ☐ Unknown

Year of diagnosis: _______________________

Have you had diabetes education? ☐ Yes ☐ No

If yes, when? _____________________________

Are you taking diabetes medication? ☐ Yes ☐ No

If yes, how often in the past week **did you miss a dose**? _________________________

Are you taking blood pressure medication? ☐ Yes ☐ No

If yes, how often in the past week **did you miss a dose**? _________________________

Health history, check all that apply (currently or past):

☐ High blood pressure	☐ Neuropathy (numbness/pain/tingling in hands & feet)	
☐ Stroke	☐ Diarrhea/loose stools	☐ Asthma
☐ Thyroid disease	☐ Heart disease	☐ Eye disease/retinopathy
☐ Kidney disease	☐ High cholesterol	☐ Foot problems
☐ Shortness of breath	☐ Problems with sexual function	☐ Depression/Anxiety
☐ Peripheral vascular disease	☐ Skin problems	☐ Slow healing wounds
☐ Memory Problems	☐ Pregnant	

List all allergies (medication, food, environmental): ____

____

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor

I understand health and medical information ☐ Yes ☐ Somewhat ☐ No

Do you believe you can improve your health? ☐ Yes ☐ Somewhat ☐ No

What is the most difficult part of managing your health? ____

My goal is to: ☐ Gain weight ☐ Lose weight ☐ Maintain current weight

Ethnicity, check all that apply:

☐ African American	☐ Asian/Pacific Islander	☐ Caucasian
☐ Hispanic/Latino	☐ Middle Eastern	☐ Native American

Primary language ☐ English ☐ Spanish ☐ Other:________________________Describe any cultural or religious practices or beliefs that influence how you care for your health:

____

Schooling, please indicate the highest level you completed:

- ☐ Elementary
- ☐ High school
- ☐ Some college
- ☐ College degree
- ☐ Graduate school
- ☐ Military training
- ☐ Technical/vocational/business school

Do you have difficulty with the following? Check all that apply:

- ☐ Hearing
- ☐ Vision
- ☐ Reading
- ☐ Working with numbers
- ☐ English language
- ☐ Other: ____________________
- ☐ Self Care, if yes describe: ____

How do you like to learn? Check all that apply:

- ☐ Listening
- ☐ Watching a video or pictures
- ☐ Doing an activity/ hands on learning
- ☐ Group discussions
- ☐ Reading

Do you have difficulty affording personal health care items, such as food, medicine, test strips?

☐ Frequently ☐ Sometimes ☐ No

KNOWLEDGE

How would you rate your understanding of diabetes?

☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Minimal

What areas would you like to learn more about? Check all that apply:

- ☐ What is diabetes, how it is diagnosed, how it progresses
- ☐ Monitoring blood sugars, targets, when & why to check it
- ☐ How to change behaviors, goal setting
- ☐ Nutrition & weight and their impact on blood sugar
- ☐ Prevention & treatment of diabetes related complications
- ☐ Problem solving, sick days, treating low & high blood sugars
- ☐ Medications, how they work (actions & benefits)
- ☐ Physical activity how it impacts blood sugar levels
- ☐ Stress & coping, creating a support plan

What is your overall diabetes goal? ____

Sun Health WELLNESS

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REDUCING RISKS

In the last year have you had the following? Check all that apply:

☐ Diabetic eye exam Month/year: ___________ ☐ Dental exam ☐ Diabetic foot exam Month/year: _______ ☐ A1C test ☐ Flu shot

Do you check your blood pressure at home: ☐ Yes ☐ No Typical results: ________

How often do you examine your feet?

☐ Daily ☐ Several times/week ☐ Few times/month ☐ Once in a while ☐ Rarely or never

Tobacco use: ☐ Current ☐ Never ☐ Quit

SUPPORT

Which of the following describes how you feel about having diabetes, check all that apply:

☐ Okay ☐ Distressed ☐ Nuisance ☐ Denial ☐ Depressed
☐ Anxious ☐ Hopeless ☐ Overwhelmed ☐ Other____

Describe the amount of stress in your life:____

Who gives you support and encouragement to take care of your diabetes? check all that apply:

☐ Family ☐ Friends ☐ Support group ☐ Co-worker ☐ Healthcare provider
☐ No One ☐ Other: ____

How sure are you that you can find the support you need to manage your diabetes?
☐ Very Sure ☐ Somewhat Sure ☐ Not At All Sure

PHYSICAL ACTIVITY

Do you have limitations that prevent you from being physically active? ☐ Yes ☐ No
If yes, describe: ____

On average how many **minutes per week** do you participate in aerobic (cardio) activities?
☐ Walking ☐ Jogging ☐ Swimming ☐ Cycling ☐ Other: ____________________________

On average how many **days per week** do you participate in muscle strengthening activities? _________________
☐ Free weights ☐ Resistance bands ☐ Weight machines ☐ Other: ______________________

How ready and willing are you to improve your physical activity routine?

☐ Not at all ☐ Thinking about it ☐ Ready ☐ Already doing it

On a scale of zero to ten, how **important** is it to be physically active to help manage your diabetes?
(zero = not important at all, ten = very important): 0 1 2 3 4 5 6 7 8 9 10

On a scale of zero to ten, what is your **confidence** in using physical activity to help manage blood sugar?
(zero = no confidence, ten = totally confident): 0 1 2 3 4 5 6 7 8 9 10

My physical activity goal is: ______________________________

HEALTHY EATING

Which of these healthy habits are you currently doing? check all that apply:

☐ Read food labels
☐ Measure food portions
☐ Limit sugar-sweetened items
☐ Other: ______________________________
☐ Include high fiber foods
☐ Choose low sodium foods
☐ Count carbohydrate grams/serving
☐ Count calories
☐ Limit saturated/trans fats

How would you rate the quality of your current eating habits?

☐ Excellent ☐ Very Good ☐ Good ☐ Poor

How ready and willing are you to improve your eating habits?

☐ Not at all ☐ Thinking about it ☐ Ready ☐ Already doing it

On a scale of zero to ten, how **important** is it to eat healthy to help manage your diabetes?
(zero = not important at all, ten = very important): 0 1 2 3 4 5 6 7 8 9 10

On a scale of zero to ten, what is your **confidence** in using healthy eating to help manage blood sugar?
(zero = no confidence, ten = totally confident): 0 1 2 3 4 5 6 7 8 9 10

Do you consume alcohol? ☐ Yes ☐ No If yes describe intake: ______________________________

MONITORING

Do you check your blood sugars? ☐ Yes ☐ No

If yes, how often?________________What time(s) of day do you test? ________________

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What is the **low to high range** of your blood sugars? ______________________________

How often do you have low blood sugars? ______________________________

How often do you have high blood sugars? ______________________________

On a scale of zero to ten, how **important** is it to check your blood sugar to help manage your diabetes?
(zero = not important at all, ten = very important): 0 1 2 3 4 5 6 7 8 9 10

On a scale of zero to ten, what is your **confidence** in using blood sugar readings to help manage blood sugar?
(zero = no confidence, ten = totally confident): 0 1 2 3 4 5 6 7 8 9 10

Do you wear medical identification or keep something with you to identify that you have diabetes?

☐ Yes ☐ No ☐ Sometimes

PROBLEM SOLVING

When you are sick and unable to eat your usual foods, what do you do? check all that apply:

- ☐ Eat/drink foods/liquids with carbohydrates
- ☐ Check blood sugar more often
- ☐ Call health care provider
- ☐ Drink more water
- ☐ None of these
- ☐ Take diabetes medications
- ☐ Check ketone levels
- ☐ Other: ______________________________

QUALITY OF LIFE

On a scale of zero to ten, how do you rate your quality of life?
(Zero = very low quality of life, ten = excellent quality of life): 0 1 2 3 4 5 6 7 8 9 10

Client Signature:______________________________ RDN Signature:______________________________

Updated: May 2018