Diabetes Education Intake Form

The following questions will help us get to know you and find out what education will be right for you. Your answers will remain confidential.

Name: __________________________________________________Birth Date: _______________________
Street Address: ________________________________City_______________________Zip:______________
Home Phone: ______________________  Cell Phone:_________________   Work Phone: _______________
Email:________________________________________    Primary Language: _________________________

Race (select all that apply)
□ American Indian or Alaska Native        □ Asian/Chinese/Japanese/Korean
□ Black or African American            □ White
□ Native Hawaiian or Other Pacific Islander    □ Middle Eastern
□ Hispanic or Latino                          □ Other: _______________

I identify as: □ Male     □ Female   □ Transgender

Education (highest level achieved):
□ 8th Grade or less  □ Some High School  □ High School Graduate /GED
□ Some College      □ College Degree (BA/BS)  □ Graduate Degree

Height._____________  Weight____________

What type of diabetes do you have?
□ Type 1                    □ Gestational        □ Other
□ Type 2                    □ Pre-diabetes       □ Do not know

What year were you diagnosed with diabetes? ______________________

Most recent A1C: _______ Date:_________  Date of next A1C test:_________

Do you have any other health problems? □ Yes       □ No       □ Don’t know
If so, please list other medical conditions________________________________________________________
__________________________________________________________________________________________

Who helps you with your medical conditions?_____________________________________________________

Do you have health insurance?     □ Yes    □ No     □ Don’t know
If yes, what health insurance do you have?________________________________________________________

Do you have emotional resources to care for your medical conditions?      □ Yes     □ No     □ Don’t know
Do you use tobacco or use other tobacco products such as e-cigarettes/vaping?  □ Yes  □ No  □ Quit
If Yes, how do you feel about cutting back or quitting?______________________________________________

Do you drink alcohol?  □ No  □ Yes:  1-2/week__ 1/day__ More than 1/day__

What do you feel are major stresses in your life? __________________________________________________
__________________________________________________________________________________________

How do you manage your stress?_______________________________________________________________
__________________________________________________________________________________________

Have you ever been diagnosed with depression?  □ Yes  □ No

Over the past two weeks, how often have you been bothered by any of the following problems? Please choose the appropriate response for each item:

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

Please state whether you agree, are neutral or disagree with the following statements

My diabetes interferes with other aspects of my life: □ agree □ neutral □ disagree

I have some control over whether I get diabetes complications or not: □ agree □ neutral □ disagree

I struggle with making changes in my life to care for my diabetes: □ agree □ neutral □ disagree

State your general feelings about your overall health ______________________________________________
__________________________________________________________________________________________

Taking medications can be an important part of keeping your chronic condition(s) under control. In order for diabetes medication to work, people have to take it as prescribed. For one reason or another, many people can’t or don’t always take all of their medication as prescribed. We want to know how often you have missed your diabetes medications. Please answer each question.

<table>
<thead>
<tr>
<th>Over the past 7 Days</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>Every time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I missed my medicine</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I skipped a dose of my medication</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>I did not take a dose of my medicine</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
Do you check your blood sugar?  □ Yes  □ No
How often:  □ Once a day  □ 2 or more/day  □ 1 or more/Week  □ occasionally
When:  □ Before breakfast  □ 2 hours after meals  □ Before bedtime

Has your blood sugar been high lately?  □ Yes  □ No  □ Don’t know
If so, what was it? __________________________

Has your blood sugar been low lately?  □ Yes  □ No  □ Don’t know
If so, what was it? __________________________

Do you have a history of an eating disorder?  □ Yes  □ No  □ Don’t know

Are you eating differently since you found out you have diabetes?  □ Yes  □ No  □ Don’t know
If yes, what type of changes have you made? ____________________________________________

How many times per day do you eat?  □ One  □ Two  □ Three  □ Four or more

Which meals do you tend to skip?  □ Breakfast  □ Lunch  □ Dinner  □ None

Who does the cooking in your house?
□ Self  □ Spouse  □ Other______________________________

“I was worried whether my food would run out before I got money to buy more.”
□ Often True  □ Sometime True  □ Never True

“The food I bought just did not last, and I did not have money to get more.”
□ Often True  □ Sometime True  □ Never True

Does your culture or religion require fasting or dietary restrictions?  □ Yes  □ No
Please explain______________________________________________________________________

Within the past 12 months, was there a time when you were not able to pay the mortgage or rent on time?  □ Yes  □ No

Within the past 12 months how many places have you lived? ________________

Within the past 12 months was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?  □ Yes  □ No

Do you exercise?  □ Yes  □ No
If no, what makes it hard for you to exercise?__________________________________________

How often do you exercise?___________________________________________________________

Check any of the following tests/procedures you have had in the last 12 months:
□ Eye exam  □ Foot exam  □ Dental exam  □ Cholesterol  □ A1c  □ Flu shot  □ Pneumonia shot
Diabetes Management/Education Plan

There are four classes in our series, which classes do you plan to attend?

☐ Introduction: the Road to Better Managing Your Diabetes
☐ Diabetes and Health Eating
☐ Monitoring Your Blood Glucose
☐ Continuing Your Journey with Diabetes
☐ Meet individually with your class diabetes educator

What do you hope to get out of this program?

____________________________________________________________________________________________
____________________________________________________________________________________________

Please select one specific goal to assist in improving your diabetes management:

I will increase my physical activity by ________________, ______________ times each week.

I will increase fruits and/or vegetable I eat by ______servings each week.

I will monitor the amount of carbohydrates I eat by ________________.

I will not buy or serve sweetened drinks such as: ____________________________.

_____ I will take my medications as prescribed.

I will check my blood sugar _____ times per day, at these times __________________________.

Other ____________________________________________________________________________________
__________________________________________________________________________________________

__________________________________________________________________________________________

Signature of Client ___________________________ Date ___________________________

Thank you! Your diabetes educator will review your responses with you during your first visit, and he or she will work with you and your doctor to develop a plan for your health.