



Class Date: \_\_\_/\_\_\_/\_\_\_  
Time: \_\_\_\_\_  
Individual Orientation  
Appt Date: \_\_\_/\_\_\_/\_\_\_  
Time: \_\_\_\_\_

## Diabetes Education Assessment

**In order for us to prepare for your participation in the Living with Diabetes: Wellness Series, please complete the following document prior to your assessment appointment.**

1. Fill out the attached assessment.
2. **Arrange for the Center for Well-Being to have a copy of the lab report for your most recent Hemoglobin A1C blood test, as well as your most recent lipid panels (cholesterol test).** Please include your lab work with this assessment and bring it to your assessment appointment or have your physician fax a copy to:

Northern California Center for Well-Being  
(707) 575-1060 - *Attention: Diabetes Educator*

3. (If applicable) enclose a check in the amount of \$\_\_\_\_\_, made out to:  
Northern California Center for Well-Being

4. Sign the statement on page 2.

5. Bring your completed assessment and glucose meter to your scheduled assessment appointment:

Northern California Center for Well-Being  
365 Tesconi Circle, Suite B  
Santa Rosa. CA 95401

**Informed Consent / Release:**

I understand that the classes at the Northern California Center for Well-Being (Center) are not medical care or treatment. They are designed as an adjunct to, and not a substitute for, medical treatment provided to me by a licensed health care provider. My signature below gives permission for the Center to exchange necessary medical information with my physician, health plan, and other health service providers. I agree to be contacted by mail or phone after completion of the class (up to two years) for the purpose of collecting follow up data from class participants. This information will enable the Center to measure the effectiveness of its classes and improve the quality of its education programs.

Exercise is designed to increase the workload on the cardiovascular system. Exercise also increases insulin sensitivity within the cells of the human body. As the cardiovascular and blood glucose response to exercise cannot be predicted with complete accuracy, I realize there are certain risks, which may occur. These include, but are not limited to, a high or low blood sugar response, injury to the bones or muscles, abnormalities of blood pressure, heart rate or rhythm; and in rare instances, heart attack or cardiac arrest. I understand that if I have any signs or symptoms of intolerance to exercise, including chest pain, nausea, shortness of breath, dizziness, fatigue, lack of coordination, or awareness of skipped heartbeats, that I am to stop exercising and consult my physician immediately. Should I have any medical condition that may affect my ability to exercise safely, I agree to inform the instructor prior to participating in any activities. I desire to engage voluntarily in supervised exercise at the Center. I agree to indemnify and hold the Northern California Center for Well-Being and any other affiliated organization, their officers, agents and employees harmless in any claims brought by me or on my behalf as a result of my participation in exercise.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**(Please print)**

**Signature** \_\_\_\_\_

**Personal Information** (please print)

<b>TODAY'S DATE:</b>		<b>FOLLOW-UP DATE:</b>		<b>(Use Red Ink For Follow-Up)</b>	
Name:		Gender: <input type="checkbox"/> male <input type="checkbox"/> female		Date of birth: Age:	
Address:		City:		State: Zip:	
Home phone:		Work:		Cell: Please <input checked="" type="checkbox"/> numbers we can use.	
Referral Source:		<input type="checkbox"/> Physician		Other	
Living Status:		<input type="checkbox"/> Alone		<input type="checkbox"/> With Others	
<b>SOCIO - ECONOMIC</b>					
Employer:		Health insurance plan(s):			
Referring physician:		No. years school completed:		Primary support person:	
Barriers to learning: <input type="checkbox"/> seeing <input type="checkbox"/> hearing <input type="checkbox"/> reading <input type="checkbox"/> depression <input type="checkbox"/> anxiety other:					
Usual amount of daily stress: 1 2 3 4 5 (5 = very high)					
<b>HEALTH CARE UTILIZATION and INSURANCE BENEFITS USED IN PAST 12 MONTHS</b>					
Insurance pays for: <input type="checkbox"/> glucose meter <input type="checkbox"/> strips <input type="checkbox"/> lancets <input type="checkbox"/> diabetes medication <input type="checkbox"/> diabetes shoes <input type="checkbox"/> Lab tests <input type="checkbox"/> doctor visits <input type="checkbox"/> diabetes education <input type="checkbox"/> medical nutrition therapy					
Number of: Hospital stays:		ER visits:		Doctor visits:	
Date		Date		Date	
Specialists seen: <input type="checkbox"/> podiatrist <input type="checkbox"/> cardiologist <input type="checkbox"/> ophthalmologist <input type="checkbox"/> counselor <input type="checkbox"/> other:				<b>Date of last dilated eye exam:</b>	
Previous diabetes education: <input type="checkbox"/> no <input type="checkbox"/> yes      Dietitian visits: <input type="checkbox"/> no <input type="checkbox"/> yes					
Do you have an annual diabetic eye exam? <input type="checkbox"/> No <input type="checkbox"/> Yes					
Do you see your dentist at least twice a year? <input type="checkbox"/> No <input type="checkbox"/> Yes					
<b>HEALTH ATTITUDES / BELIEFS / GOALS</b>					
Feelings about having diabetes:			Rate your health: <input type="checkbox"/> excellent <input type="checkbox"/> good <input type="checkbox"/> fair <input type="checkbox"/> poor		
<b>Do you feel:</b> Diabetes is serious? <input type="checkbox"/> no <input type="checkbox"/> yes    You can control it? <input type="checkbox"/> no <input type="checkbox"/> yes Controlling it is worth it? <input type="checkbox"/> no <input type="checkbox"/> yes					
I want to learn more about: <input type="checkbox"/> diet <input type="checkbox"/> exercise <input type="checkbox"/> preventing complications of diabetes <input type="checkbox"/> stress management <input type="checkbox"/> How to test my blood sugar <input type="checkbox"/> tests to take regularly and target values <input type="checkbox"/> other:					

**EATING HABITS**

**On each line, select 1 letter for AMOUNT usually eaten: H = High M = Moderate L = Low**

Starches:	Fruits / Juices:	Sugary Foods:	Sugary Drinks:
Vegetables:	Milk/Yogurt:	Meat/Fish:	Cheese:
Eggs:	Fat / Fatty Foods:	Salt / Salty Foods:	Fast Food:
How often do you eat out?		Who buys food?	Who cooks?
Do you use a <b>food/meal planning system</b> ?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, which system?		<input type="checkbox"/> No Added Sugar	
<input type="checkbox"/> Exchange System		<input type="checkbox"/> Carbohydrate counting	
<input type="checkbox"/> Carbohydrate counting		<input type="checkbox"/> Healthy Choices	

**EXERCISE and LIFESTYLE HABITS**

Type(s) of exercise:	How often?	How long each time?	OK'd by doctor?
<input type="checkbox"/> < 30 minutes per week	<input type="checkbox"/> < 30 minutes per week	<input type="checkbox"/> 30 - 60 minutes per week	
<input type="checkbox"/> 1-3 hours per week	<input type="checkbox"/> 30 - 60 minutes per week	<input type="checkbox"/> >3 hours per week	
Do you smoke?	<input type="checkbox"/> yes <input type="checkbox"/> no	How long?	No.: <input type="checkbox"/> packs <input type="checkbox"/> cigarettes <input type="checkbox"/> cigars a day is:
Do you drink alcohol?	<input type="checkbox"/> yes <input type="checkbox"/> no	How long?	No.: drinks: <input type="checkbox"/> per week or <input type="checkbox"/> per day is:
Do you inspect your feet daily?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Do you carry diabetes identification?	<input type="checkbox"/> No <input type="checkbox"/> Yes		

**HEALTH STATUS**

Height:	Weight:	<input type="checkbox"/> shoes <input type="checkbox"/> no shoes	Desired wt:	Wt 1 year ago:
---------	---------	--	-------------	----------------

**Regarding Your Glucose Monitoring:**

Do you have a meter to measure your blood sugar level?

No – if no, please skip to “Diabetes History and Current status”.

Yes, do you know how to use it?  No  Yes

If yes, during the last week did you test your blood sugar level at least...?

4 or more times a day  2-3 times a day  daily  once

Other \_\_\_\_\_

Do you have a target blood sugar range?  No  Yes, what is it?

70 – 120  70 – 150  80 – 180  100 – 200  Under 250

Blood sugar **before** meals: \_\_\_\_\_ mg  don't know

Blood sugar **after meals** & before **bedtime**: \_\_\_\_\_  don't know

How often do you: Don't know Never Sometimes Frequently

- Have low blood sugar?  Don't know  Never  Sometimes  Frequently
- Have high blood sugar?  Don't know  Never  Sometimes  Frequently
- Have urine ketones?  Don't know  Never  Sometimes  Frequently

Do you get **low blood sugar** reactions?  No  Yes – when? \_\_\_\_\_

How do you treat your low blood sugar? \_\_\_\_\_

Do you take **Insulin**?  No  Yes – how often per day?  Once  Twice  3 or more

Do you ever skip a dose, or take extra doses of your meds?  No  Yes

If yes, explain: \_\_\_\_\_

Note any non-diabetes medications, over-the-counter medications, vitamins, herbs, or supplements that you take: \_\_\_\_\_

**Problems You Have Which May Make Learning or Caring for Your Diabetes Difficult**

- seeing  hearing  reading  understanding or reading English
- mental illness  work issues  learning disability  medical or health problems
- hyperactive  family issues  staying focused
- money issues  transportation  other \_\_\_\_\_

**For Problems You Checked Do you do ANY of the Following to Help Reduce the Problems?**

- wear glasses or contacts  use magnifying glass  someone reads material to me
- someone explains instructions  use an interpreter  wear hearing aides
- bring someone with me  use public transportation  have someone drive me
- take medication for the problem  Other \_\_\_\_\_

**DIABETES HISTORY and CURRENT STATUS**

Diabetes diagnosed in year: \_\_\_\_\_ Type of diabetes:  Type 2  Type 1  Gestational  don't know

Other diabetics in family?  No  Yes (relationship) \_\_\_\_\_

On a scale of 1-5, how confident do you feel about your ability to manage your diabetes?

**Not confident**

**Very confident**

- 1  2  3  4  5

Diabetes Medication(s)	Amount in Dose	Times Taken	Side Effects	Staff Only: Changes

I test my blood sugar \_\_\_times a  day  week  month  don't test Record results:  yes  no

Blood glucose meter name: \_\_\_\_\_



**USUAL FOOD EATEN IN ONE DAY AND AMOUNTS**

<b>BREAKFAST</b>	
<b>Time:</b>	
<b>SNACK</b>	
<b>Time:</b>	
<b>LUNCH</b>	
<b>Time:</b>	
<b>SNACK</b>	
<b>Time:</b>	
<b>DINNER</b>	
<b>Time:</b>	
<b>SNACK</b>	
<b>Time:</b>	
<b>OTHER?</b>	
<b>Time:</b>	
<b>Educator's Signature:</b>	
<b>Date:</b>	

**FROM THIS POINT STAFF USE ONLY**

Test	Targets	Pre :	Post :	Date:	Date:	Date:	Date:
FBG	90 - 130						
A1c	≤ 7%						
T Chol	≤ 200						
LDL-C	≤ 100 or 70						
HDL-C	≥ 40 or 50 (F)						
Triglycerides	≤ 150						
BP	≤ 130/80						
S. Creatinine							
BUN							
Est. GFR							
Microalbumin							
Weight		<input type="checkbox"/> shoes <input type="checkbox"/> none	<input type="checkbox"/> shoes <input type="checkbox"/> none	<input type="checkbox"/> shoes <input type="checkbox"/> none	<input type="checkbox"/> shoes <input type="checkbox"/> none	<input type="checkbox"/> shoes <input type="checkbox"/> none	<input type="checkbox"/> shoes <input type="checkbox"/> none
BMI							

**Notes:**