For Program Purposes
PCP
Ht.
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CMA Diabetes Education Intake Form

Please answer the following questions.

1. What year were you diagnosed with diabetes?_____

2. Have you had diabetes education before? **Y** **N**

What month/year?_____

3. What medications do you take for your Diabetes: _____

_____

4. Do you currently use a blood sugar meter? **Y** **N** How many times a day?_____

5. How many days a week you exercise? **None** **1-2** **3-5** **6-7** What do you do?_____

6. Has your diabetes caused you to need to call 911, visit the emergency department, be admitted to the hospital, or miss work/school/activities in the last 3 months? **Y** **N**

7. Have you been diagnosed with, or told you have any of the following? (Circle all that apply)

High Blood Pressure Heart Disease/Chest Pain Eye or Vision Issues Stroke Severe Hypoglycemia Foot Issues High Cholesterol Kidney Problems Thyroid Disease Numbness or Pain in a Hands or Feet Frequent Nausea Depression/Anxiety Sexual Dysfunction Smoker

8. Have you had the listed tests in the past year? (Place an X in the appropriate box)

Test	**Yes**	**No**	**Unsure**
A1C			
Urine Protein			
Foot Exam			
Eye Exam			
Flu Vaccine			
Lipids Checked			

9. Have you ever had a pneumonia vaccine **Y** **N** When?_____

10. Have you visited with a dietician before? **Y** **N** What month/year?_____

11. Has your weight changed by 10 or more pounds, in the last year? **Y** **N** **Lost or Gained?**

12. How many days a week do you eat fast food?_____

13. How would you rate your level of stress?(circle one)

1-Very Low to None **2-Low** **3-Neutral** **4-Slightly High** **5-Very High**

14. What activities or resources help you when you have stress?

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15. Who do you turn to for help or support? Does this person live with you? **Y** **N**

16. Do you have limitations that affect your ability to manage your diabetes?
(Circle all that apply)

Hearing Loss ***Vision Loss*** ***Nerve Pain in Hands or Feet*** ***Other***_____

17. Are there any cultural considerations that make managing your diabetes difficult? **Y** **N**

Please describe._____

18. Do you have difficulty affording your diabetes medications and diabetes supplies? **Y** **N**

19. What do you find the most challenging about living with diabetes?

20. How motivated are you in making changes to maintain your health? (Circle one)

5-Very **4-Somewhat** **3-Neutral** **2-Not Really** **1-Not at All**

21. What are some of the questions you have about diabetes that you would like to talk about?

Thank you for taking the time to answer these questions. Understanding your individual needs will help us to come up with the best education plan for you.