Diabetes Self-Management Training
Participant Questionnaire/Self Assessment
For Adults

General Information:

Name: _____Date_____

Address: _____

_____ Age: _____

What name would you like used in class? _____

Person filling out form: _____

Relationship: _ _____

Reason for not filling out form yourself: _____

How did you hear about this program? _____

Check your racial/ethnic group

- ❑ White/Caucasian
- ❑ African American/Black
- ❑ American Indian or Alaskan Native
- ❑ Other_____
- ❑ Asian/Chinese/Japanese/Korean/Pacific Islander
- ❑ Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino

Social:

Do you work? ❑ Yes ❑ No ❑ Retired ❑ Disabled ❑ Student

Type of job and work hours? _____

If retired, how long and from what job? _____

Who lives with you? _____ _____

How far did you go in school? _____ How do you learn best? (check **all** that apply)

- ❑ Reading
- ❑ Listening
- ❑ Group discussion
- ❑ Seeing/visual
- ❑ Doing
- ❑ Watching videos/TV
- ❑ Computer
- ❑ Other_____

What language do you use at home? _____

Does your insurance cover all or part of:

- ❑ Health Care Provider Visits
- ❑ Diabetes Education

Supplies: ❑ meters ❑ strips ❑ lancets ❑ other

(Note: Call insurance for this information)

If you have no insurance, can you pay for these things? ❑ Yes ❑ No

Medical History:

Have you ever or do you now have any of the following:

❑ High blood Pressure	❑ High Cholesterol	❑ High Triglycerides
❑ Heart Disease	❑ Stroke	❑ Arthritis
❑ Thyroid Disease	❑ Depression	❑ Mental Health Problems
❑ Kidney Disease	❑ Poor Leg Circulation	❑ Amputation
❑ Eye Disease	❑ Dental Disease	❑ Stomach or Bowel Problems
❑ Sexual Problems	❑ Skin Problems	❑ Pain or Fatigue Syndromes
❑ Recent/Frequent Infections	(Type) _____	❑ Allergies (include food)
❑ Osteoporosis	❑ Other _____	_____

Have you ever had a pneumonia shot? ❑ No ❑ Yes: Date: _____
Do you get flu shots? ❑ No ❑ Yes: Date of last flu shot: _____
Do you drink alcohol? ❑ No ❑ Yes: What kind? _____
How much do you usually drink? ❑ Daily ❑ 2-4 times/week
❑ Once a week ❑ Occasionally ❑ Other _____
Do you smoke cigarettes? ❑ Yes ❑ No
If yes, would you like information about quitting? ❑ Yes ❑ No

All Medications: Include those needing a prescription and those not needing a prescription "over-the-counter" (for example, aspirin, pain relievers)

Name of Medication	Amount	What is it for?

If on insulin, method of administration: ❑ Pen ❑ Pump ❑Syringe
Date insulin started_____If on insulin, do you have glucagon? ❑ Yes ❑ No

Do you use vitamins, herbal or home remedies, supplements or teas?
❑ No ❑ Yes: List

Vitamin/supplement/herbal/home remedy/teas	What do you take it for?

Nutrition:

Ht._____ Wt._____ or BMI (body weight index) _____
Is your current weight comfortable? ❑ Yes ❑ No
Have you ever seen a dietitian (RD) for diabetes? ❑ Yes ❑ No If yes, when? _____
Do you have a meal plan? ❑ Yes ❑ No Do you follow it? ❑ Yes ❑ No; If no, why not?
_____
How many meals do you eat every day? _____
How many snacks daily? _____ What kind? _____

Do you have any religious/family customs or celebrations that involve food or eating?
Explain: _____
Who cooks? _____ Who shops? _____
How often do you eat out or bring home "take out"? _____
Where? _____

Diabetes History:

What type of diabetes do you have? _____ ❑ Not sure For how long: _____
Have you had diabetes education in the past? ❑ No ❑ Yes (check box below and write date and place)

❑ Self-taught (explain how):_____
❑ Doctor's office:
Name:_____
❑ Group classes:
_____
❑ one-to-one meeting/s with diabetes educator_____

Do you check your blood sugar? ❑ No ❑ Yes: How often _____and what do they run?_____
Have you ever had a low blood sugar? ❑ No ❑ Yes: How often_____
How did you feel? _____What did you do?_____
Have you ever had a high blood sugar? ❑ No ❑ Yes: How often?_____
How did you feel? _____What did you do?_____
_____
Do you test for urine for ketones? ❑ No ❑ Yes ❑ Don't know what ketones are.
Have you had an "A1c test" (3 month test)? ❑ No ❑ Uncertain ❑ Yes: Date: _____ Result:
_____
Have you been hospitalized for diabetes in the past 12 months? ❑ No ❑ Yes: Where?_____
_____
How may times? ❑ 1 ❑ 2-4 ❑ greater than 4

Do you know what the results were for any of the following tests?

Test	Result	Date
Low density lipid (LDL)		
High density lipid (HDL)		
Cholesterol		
Triglycerides		
Microalbuminuria		
Blood pressure (BP)		

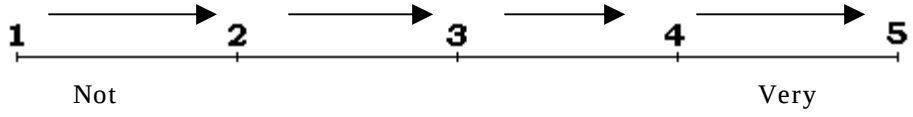
Have you ever had a dilated eye exam? ❑ No ❑ Yes: Date: _____
Do you do a self foot exam? ❑ No ❑ Yes: How often? ❑ Daily ❑ Weekly ❑ Monthly
Have you ever had a foot exam by a doctor? ❑ No ❑ Yes: Date: _____
How often do you go to the dentist?_____
Do you carry diabetes identification? ❑ Yes ❑ No

Activity/Exercise:

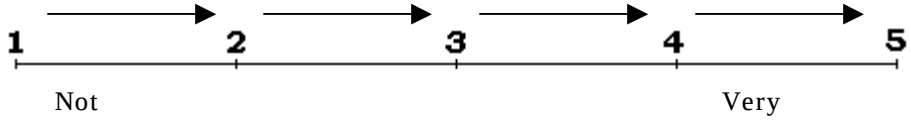
How often are you active? ❑ None ❑ Some ❑ Often
Are you as active as you think you should be? ❑ Yes ❑ No; if no, why not? _____
_____
What do you do to be active or to exercise_____
_____

More About You

How interested are you about learning more about diabetes?



How stressed are you?



How do you handle things that worry you? _____ _____

How has diabetes affected your life: or if diabetes is new, how do you think diabetes will affect your life? _____ _____

What will be, or is the hardest part of taking care of your diabetes?

_____

My diabetes is a ❑ Disaster ❑ Burden ❑ Problem ❑ Challenge ❑ Opportunity ❑ Other_____

_____

What are some of the ways your family might have treated diabetes?

_____

How does your faith or religion help you to be well? _____

Name one goal you have for your diabetes:_____ _ _____

_____

For Women only:

Are you pregnant? ❑ No ❑ Yes: Due date: _____
Do you plan on becoming pregnant? ❑ Yes ❑ No
What method of birth control do you use? _____

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For Instructional Staff Only: Education Plan: ❑ Provide instruction for specific content area/s checked on "Education Plan and Record" ❑ Individual appointments ❑ Group classes ❑ Plan to address special educational
needs_____-
_____

Reviewed by:_____Date:_____

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