Diabetes Control Center

Type 1 and Type2 Diabetes Assessment Form

Name: _____Age: _____ D.O.B._____ Preferred Language _____

Do you have a pacemaker or other implants? ☐ Yes ☐ No _____ Could you be pregnant? ☐ Yes ☐ No

Do you use computers to search for health information or for e-mail? ☐ Yes ☐ No

How do you prefer to communicate? ☐ Verbal ☐ Written ☐ Other _____

What is your preferred learning style? ☐ None ☐ Demonstration ☐ Printed materials ☐ Verbal explanation ☐ Video/TV ☐ Other

Rate your reading skills: ☐ Good ☐ Fair ☐ Poor

Do you use any of the following? ☐ Contacts ☐ Eye glasses ☐ Hearing aids ☐ Other _____

Do you have? ☐ Type 1 - Year of diagnosis _____ ☐ Type 2 - Year of diagnosis _____

How many people live with you in your home? _____ How are they related to you? _____

Previous diabetes education ☐ Yes ☐ NO Location/Year: _____

Highest education level? ☐ Grade school ☐ High school ☐ College ☐ Post graduate ☐ Skills trade

Have you been seen in the emergency room or admitted to the hospital in the last 12 months? ☐ Yes ☐ No

Was the ER or hospitalization diabetes related? ☐ Yes ☐ No

How often do you miss taking your medications? ☐ Often ☐ Sometimes ☐ Rarely ☐ Never ☐ Other_____

When do you check your blood sugar? ☐ before breakfast ☐ before lunch/dinner ☐ 2 hours after meals ☐ before bed ☐ never ☐ occasionally Name of glucometer_____

What has your blood sugar range been in the past 30 days? _____ ☐ I don't know

If you blood sugar is too high, what do you do to bring it down? _____

Do you check your urine for ketones? ☐ Yes ☐ No

Number of low blood sugars in past month? _____ How did you treat it? _____

Do you have glucagon? ☐ Yes ☐ No

Have you had any of the following done in the past year?

☐ Urine test for protein ☐ Feet checked by doctor ☐ Dental exam ☐ Dilated eye exam ☐ Flu vaccine ☐ Pneumonia Vaccine

What is your exercise routine? Type_____ How long?_____ Times per week?_____

Do you wear medical ID? ☐ Yes ☐ No

Any Religious/Spiritual or Cultural/Ethnic practices or beliefs related to your healthcare? _____

What are you most interested in learning about your diabetes? _____

Do you feel diabetes interferes with your life? ☐ Yes ☐ No

Do you feel you have control over diabetes complications? ☐ Yes ☐ No

Patient Label

DCCAST

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Do you struggle making changes regarding diabetes? ☐ Diet ☐ Physical activity ☐ Taking medications ☐ Checking blood sugar

What best describes how you feel about having diabetes?
☐ Fear ☐ Denial ☐ Anger ☐ Overwhelmed ☐ Acceptance ☐ Other_____

Feelings of being overwhelmed by the demands of living with diabetes:
☐ No problem ☐ Slight problem ☐ Moderate problem ☐ Serious problem

Feelings that you are off track with your diabetes routine:
☐ No problem ☐ Slight problem ☐ Moderate problem ☐ Serious problem

What is your occupation? _____ Works night shift ☐ Yes ☐ No Rotating shifts ☐ Yes ☐ No

My stress level is: ☐ Low ☐ Moderate ☐ High

My stress factors are: ☐ Financial/money ☐ Job ☐ Health ☐ Personal/home ☐ Other_____

Within the past 12 months we worried whether our food would run out before we had money to buy more?
☐ Often true ☐ Sometimes true ☐ Never true

Within the past 12 months the food we bought just didn't last and we didn't have money to get more?
☐ Often true ☐ Sometimes true ☐ Never true

Do you have any special dietary needs?

- ❑ Vegetarian
- ❑ Gluten Free
- ❑ Heart healthy
- ❑ Low fiber
- ❑ Lactose free
- ❑ Other with text box

What type of food changes have you made since being told you have diabetes?

- ❑ Less sugary beverages
- ❑ Smaller portions
- ❑ More vegetables
- ❑ Less fatty or fried foods
- ❑ Eating out less
- ❑ Other with text box

How many times per day do you eat?

- ○ One
- ○ Two
- ○ Three
- ○ Four or more

Who does the cooking? □ Self □ Other

Any weight change in the past 6 months? ☐ Increased ☐ Decreased What weight are you most comfortable with?_____

Other than diabetes, list your past health history or surgical history? _____

Ever used tobacco? ☐ No ☐ Yes Year quit?_____ Type? ☐ Cigarettes ☐ Cigars ☐ Vaping How many per day? _____

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week _____ ☐ Type_____

Do you feel safe at home? ☐ Yes ☐ No Comment? _____

Do any family members have diabetes? ☐ No ☐ Yes who? _____

Have you received a COVID vaccine? ☐ Yes ☐ No ☐ Prefer not to say ☐ Pfizer ☐ Moderna ☐ J&J ☐ Unsure

Are you fully vaccinated? ☐ Yes ☐ No ☐ Received booster? ☐ Yes ☐ No

Number of times been pregnant? _____ Number of live births _____ Was birth weight greater than 8 pounds? ☐ Yes ☐ No

Are you experiencing pain? ☐ Yes ☐ No Location?_____ Intensity (0-10)? ___ Describe:_____

Is your pain managed by your doctor? ☐ Yes ☐ No Have you fallen in the last 3 months? ☐ Yes ☐ No

Ever have dizziness or vertigo? ☐ Yes ☐ No Ever wet or soil yourself on the way to the bathroom? ☐ Yes ☐ No