DIABETES ASSESSMENT FORM

Name: ___________________________________________ Date: ______________________

Being a person with diabetes means ________________________________________________
__________________________________________________________________________________

When I think about having diabetes, I feel _____________________________________________
__________________________________________________________________________________

How do I feel about giving up old habits and starting new ones in order to improve my health? ________________________________________________________________

Do I believe it simply doesn’t matter if I change my habits? __________________________________

Do I lack self-confidence in my ability to make changes? __________________________________

Getting Ready

What can I do to make a difference in my physical and emotional health? ____________________________________________________
__________________________________________________________________________________

Is there anything I should do to prepare myself for these changes? __________________________________________________________
__________________________________________________________________________________

Who is available to help me? ___________________________________________________________________________________________

What can they do to help me? ___________________________________________________________________________________________

Diet

Which of the following has your health care team (doctor, nurse, dietician or diabetes educator) advised you to do?
Please check all that apply:

☐ Follow a low-fat eating plan.
☐ Reduce the number of calories you eat.
☐ Eat 5 servings per day of fruits and vegetables.
☐ Eat very few sweets.
☐ Other (specify): ________________________________
☐ You have not been given any advice about your diet.

How often did you follow your recommended diet since your last visit? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Physical Activity

Which of the following has your health care team (doctor, nurse, dietician or diabetes educator) advised you to do? Please check all that apply:

☐ Do low to moderate activity (such as walking) on a daily basis.
☐ Exercise continuously for at least 20 minutes at least 3 times a week.
☐ Fit physical activity into your daily routine (take stairs instead of elevators, park a block away and walk).
☐ Other (specify): ________________________________
☐ You have not been given advice about physical activity.

How often did you follow your exercise recommendations since your last visit? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

continued ➤
Self-Monitoring of Blood Glucose
Which of the following has your health care team (doctor, nurse, dietician or diabetes educator) advised you to do?
Please check all that apply:

☐ Test your blood glucose (sugar) using a drop of blood from your finger.
☐ Test your urine for sugar.
☐ Test your blood glucose using a machine to read the results.
☐ Other (specify): __________________________
☐ You have not been given advice about testing your blood glucose.

How often did you follow your blood glucose testing recommendations since your last visit?
☐ Always  ☐ Usually  ☐ Sometimes  ☐ Rarely  ☐ Never

Diabetes Medication
Which of the following medications for your diabetes has your doctor prescribed? Please check all that apply:

☐ An insulin shot 1 or 2 times a day.
☐ An insulin shot 3 or more times a day.
☐ Diabetes pills to control your blood glucose level.
☐ Glucophage (Metformin tablets).
☐ Other (specify): __________________________
☐ You have not been prescribed medication for your diabetes.

How often did you take your diabetes medication since your last visit?
☐ Always  ☐ Usually  ☐ Sometimes  ☐ Rarely  ☐ Never

Foot Care
Which of the following has your health care team (doctor, nurse, dietician or diabetes educator) advised you to do?
Please check all that apply:

☐ Check your feet daily for sores cuts, calluses, infection, etc.
☐ Check inside your shoes daily for loose objects or rough edges.
☐ Not to go barefoot either inside or outdoors.
☐ Wash your feet daily, remembering to dry between your toes.
☐ Other (specify): __________________________
☐ You have not been given advice about foot care

How often did you follow your foot care recommendations since your last visit?
☐ Always  ☐ Usually  ☐ Sometimes  ☐ Rarely  ☐ Never

Smoking
Have you smoked, even a puff, during the last 7 days? ☐ Yes  ☐ No (skip to next section)

Has anyone from your health care team advised you to stop smoking? ☐ Yes  ☐ No

Are you seriously considering stopping smoking in the near future? ☐ Yes  ☐ No

Managing Symptoms
Has your health care team instructed you what to do if your blood glucose is too low or too high? ☐ Yes  ☐ No

How confident are you that you know what to do if your blood glucose is too low?

Not confident  ☐ Confident

1  2  3  4  5  6  7

How confident are you that you know what to do if your blood glucose is too high?

Not confident  ☐ Confident

1  2  3  4  5  6  7

Thank you for taking the time to fill out this form.