Pure Nutrition LLC
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DIABETES ASSESSMENT

Name: Date:

SOCIO - ECONOMIC / LEARNING		
Employer:	Health insurance plan(s):	
Referring physician:	No. years school completed:	Primary support person:
Barriers to learning: seeing hearing reading depression anxiety attention deficit How I learn best: verbal discussions written materials videos combination other:		
Daily stress level: 1 2 3 4 5 (5 = very high) How I deal with it:		

HEALTH CARE UTILIZATION and INSURANCE BENEFITS USED IN PAST 12 MONTHS
Insurance pays for: glucose meter strips lancets diabetes medication diabetes shoes lab tests doctor visits diabetes education medical nutrition therapy
Number of: Hospital stays: ER visits: Doctor visits: Outpatient visits:
Specialists seen recently: foot doctor cardiologist eye doctor dentist counselor other:
Previous diabetes education: □yes □ no Dietitian visits: □ yes □ no

DIABETES HEALTH ATTITUDES / BELIEFS / EDUCATIONAL GOALS
My understanding of diabetes is: good fair poor My overall health is: good fair poor My feelings about having diabetes: ____________________ Do you feel: Diabetes is serious? yes no You can control it? yes no Good control is worth it? yes no **I want to learn how to:** Eat healthy Be active Use healthy coping strategies Treat high and low blood sugar Test blood sugar regularly Take medications as directed and why Reduce risks of complications involving blood pressure, eyes, kidneys, heart, feet, etc. *Now circle the **ONE** area you want to focus on the **MOST** to start positively changing your behavior!*

EATING HABITS			
On each line, select 1 letter for AMOUNT usually eaten: H = High M = Moderate L = Low N = None			
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?

EXERCISE and LIFESTYLE HABITS			
Type(s) of exercise:	How often?	How long each time?	OK'd by doctor?
Do you smoke? yes no	How long?	No.: packs cigarettes cigars a day is:	

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HEALTH STATUS

Height: Weight: shoes no shoes Desired wt: Wt 1 year ago:

Fasting glucose (from lab): A1C: Total cholesterol: LDL: HDL:

Triglycerides: Blood pressure: Do you get yearly flu shot? yes no

MEDICAL HISTORY and CURRENT STATUS

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

Other medical problems, surgeries, etc., **besides diabetes**:

Medication(s)	Amount in My Dose	Times Taken	Reason for Taking	Staff Only: Changes

Vitamins, dietary supplements or herbs taken:

Allergies:

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

Blood glucose meter name:

I test: Fasting Before meals After meals Bedtime 2-3 a.m.

Test Results: Fasting: Before meals:
After meals: Bedtime: 2-3 a.m.:

Recent Episodes of:
high blood sugar coma diabetic ketoacidosis
high blood sugar (250 or more)……occurs about _________ times a month
low blood sugar (70 or less)………occurs about _________ times a month
ketones in urine………………….…..occurs about _________ times a month

Diabetes has caused a **problem** in these areas of my life: family life social activities work/school travel finances sports/exercise sexual relations peace/contentment other:

Diabetes Complications: ***If checked, rate degree: S = Severe M = Moderate L = a Little***

Eyes / Vision (blurry, sight loss)______
Nerves (numbness, sensations)_______
Kidney___________________________
Feet____________________________
Diarrhea_________________________

Heart / Artery Disease_______
Teeth / Gums______________
Frequent Infections__________
Skin (dry, itchy)____________
Constipation________________

Other **diabetes** problems:

CULTURAL / RELIGIOUS FACTORS

Special dietary customs, needs, observances:

Food fasting practices:

(WOMEN) SEXUALITY / REPRODUCTION / PREGNANCY
Number of pregnancies: Number children born alive: Birth weights:
Pregnancy complications: Sexual problems now: vaginal dryness loss of libido Plans to get pregnant: yes no maybe If pregnant now: pre-pregnancy weight: No. weeks pregnant: Due date:
(MEN) SEXUALITY
Sexual problems now: impotence loss of libido Other:

USUAL FOOD EATEN IN **ONE TYPICAL** DAY AND AMOUNTS		
BREAKFAST Time:	**LUNCH Time:**	**DINNER Time:**
SNACK Time:	**SNACK Time:**	**SNACK Time:**

	*Please place a **check mark (✓)** next to the **ONE** statement below that **BEST** pertains to you right now.*	**SOR***
	No, I do not plan to make changes in my diabetes care in the **next 6 months**.	**PC**
	Yes, I do plan to make changes in my diabetes care in the **next 6 months**.	**C**
	Yes, I do plan to make changes in my diabetes care in the **next month**.	**P**
	Yes, I have already made changes in my diabetes care for at **least the last 6 months**.	**A**
	My diabetes has been in good control, and has stayed there, for **more than 6 months**.	**M**
	My diabetes had been in good control for more than 6 months, but then **returned** to poor control.	**R**

Educator: _______________________________________ Date: ________________________