Taddle Creek Diabetes Education Program
Intake Form: Self-Assessment

Name: ______________________________ Date of Birth: ____________________
(day/month/year)

Instructions for Completing this Form

Thank you for taking the time to complete this form at home. This information is important in helping us get to know you and will also allow more time for us to talk with you at your first visit.

Please print clearly. If you have any difficulty filling out the form, please ask someone to help you complete it.

*****All of the information you provide will be kept confidential within your patient file at Taddle Creek DEP. A report with recommendations from your Diabetes Educator will be sent to your Primary Care Provider and/or Referring Physician after each visit to provide you with the best care possible.*****

Diabetes History

When did you find out that you have diabetes/prediabetes? __________________________
month/year

Have you had any previous diabetes education? ☐ Yes ☐ No

If yes, where? _________________________________ When? _______________
Name of Diabetes Program month/year

Present **Complaints/Problems**: (please check (✓) all that you have now)

☐ Increased thirst ☐ Itchy Skin ☐ Headache ☐ Need to urinate often
☐ Infections ☐ Blurred vision ☐ Tiredness ☐ Losing weight
☐ Other(s): ____

Do you have a **family history** (parents, siblings, or children) of the following:

Diabetes	☐ Yes	☐ No	☐ Don't know
Heart Disease	☐ Yes	☐ No	☐ Don't know
High Blood Pressure	☐ Yes	☐ No	☐ Don't know
Obesity	☐ Yes	☐ No	☐ Don't know
High Cholesterol	☐ Yes	☐ No	☐ Don't know

Health Status

Do you take any **medications** (including insulin, vitamins or supplements)? ☐ Yes ☐ No

If yes, please list: ____
____
____

Have you been seriously ill or in the **hospital** in the last 12 months? ☐ Yes ☐ No

If yes, what was this illness or the reason for your stay? _____________________________
____

Do you have any of the following **health problems**? Please check (✓) all that apply.

☐ **None**

☐ Hearing problems
☐ Eye or vision problems
☐ High blood pressure
☐ Heart problems
☐ Stroke
☐ Cholesterol problems
☐ Numbness or tingling in your body (hands, feet, etc)
☐ Other:_______________________________________
☐ Circulation problems
☐ Arthritis
☐ Cancer
☐ Depression
☐ Chronic pain
☐ Breathing problems
☐ Kidney problems
☐ Urinary infections
☐ Bladder problems
☐ Bowel problems
☐ Thyroid problems
☐ Sexual problems
☐ Sleep Apnea

Have you had an ☐**ECG/EKG** or ☐ **Stress Test** done in the past year? (These are tests that measure how well your heart is working.) ☐ Yes ☐ No ☐ Unsure

If yes, were the results normal? ☐ Yes ☐ No ☐ Don't know

Do you **smoke**? ☐ Yes ☐ No If yes, how many cigarettes/day? ______________

If no, did you ever smoke? ☐ Yes ☐ No

Do you drink **alcohol**? ☐ Yes ☐ No If yes, what do you drink? ____________________

How much and how often? ____

Do you use **social drugs** (for example, marijuana, cocaine)? ☐ Yes ☐ No

If yes, what do you use and how often? ____

For Women of Child-Bearing Age:

Are you planning a pregnancy? ☐ Yes ☐ No

How often do you see the following healthcare providers? Please fill in the appropriate names and dates.

	Name	Never seen	How often do you have Appointments? (i.e. every 3 months)	Last Appointment (month/year)
Family Doctor				
Diabetes Doctor				
Eye Doctor				
Dentist				
Foot Care Provider				
Other Specialist: (Type and name)				

Do you get an **annual flu shot?** ☐ Yes ☐ No Last Date: ____________________

Have you received a **Pneumococcal Vaccine** ☐ Yes ☐ No Last Date: ____________________

Social and Emotional Health Assessment

Over **the past 2 weeks**, how often have you been bothered by any of the following problems?

(0 = not at all, 1 = several days, 2 = more than half the days, 3 = every day)

1. Little interest or pleasure in doing things
   0 1 2 3
2. Feeling down, depressed or hopeless
   0 1 2 3

Do you **live alone**? ☐ Yes ☐ No

If no, who do you live with? ______________________________

Who do rely on when you need **help/support**? ______________________________

Are you currently **employed**? ☐ Yes ☐ No ☐ Retired ☐ Self-employed

If yes, what do you do? __________ ☐ full-time ☐ part-time ☐ shift-work

Do you have any **financial concerns**? ☐ **None** ☐ diabetes supplies ☐ medications ☐ food

☐ Other: ______________

Do you have a **drug plan**? ☐ Private ☐ ODP (Senior's Drug plan) ☐ OW (Ontario Works)

☐ ODSP (Long-Term Disability) ☐ none

Do you have any religious, family, or cultural practices that influence how you care for your health?

☐ No ☐ Yes: ______________________________

Diabetes Self Management

Do you **test your blood sugars** at home using a meter? ☐ Yes ☐ No

If yes, how often? ______________________

Have you had symptoms of **low blood sugar** (weakness, dizziness, hunger)? ☐ Yes ☐ No

If yes, how often(check or circle): Daily Weekly Monthly Don't know

Are you **physically active**? ☐ Yes ☐ No ☐ Advised not to by Doctor

If yes, what type of activity/exercise? ______________________________

How often and when? ______________________________

How many hours a day to you spend sitting in front of the TV and/or computer? ______

Nutrition and Dietary History

What is your **usual weight**? __________ Pounds Kilograms What is your **height**? __________ feet/cm(circle)

Are you happy with your current weight? ☐ Yes ☐ No

Has your **weight changed** in the last 6 months: ☐ Yes ☐ No ☐ Don't know

If yes, how much have you ☐lost or ☐gained? __________ Pounds Kilograms

Have you ever **seen a dietitian** for counseling before? ☐ Yes ☐ No

If yes, when and where? ____

Have you been involved in a diet/weight loss program (eg. Weight Watchers, Atkin's diet, Dr. Bernstein) in the past? ☐ Yes ☐ No

If yes, which program: ____

Please check (✓)any of the following **problems**:

☐ Constipation and/or diarrhea ☐ Irritable bowel syndrome ☐ Poor appetite
☐ Chewing and/or swallowing ☐ Crohn's disease ☐ Diverticulitis
☐ Celiac disease ☐ Food allergies or sensitivities: ____________________

Who **prepares the meals** at home? (check one or more)

☐ Self ☐ Spouse ☐ Other: ____

How often do you prepare meals? ___________________________________

Do you ever **skip meals**? ☐ Yes ☐ No

If yes, how often? _______ (times per week) What meal(s)? ______________________________

Who does the **grocery shopping**? (check one or more)

☐ Self ☐ Spouse ☐ other: ____

Do you eat in response to emotions (☐**stress** or ☐**boredom)**? ☐ Yes ☐ No

If yes, how often and what do you choose? ____

Have you **changed your eating habits** in the past 6 months? ☐ Yes ☐ No

If yes, in what way? (check one or more) ☐ How much you eat ☐ When you eat
☐ Types of food you eat

Please explain: ____

What kinds of **liquids** do you use to hydrate yourself? ____

How many cups (250 ml) of all liquids do you usually drink in a day? _______________

Personal Needs

What is the main reason **why you were referred** to Taddle Creek Diabetes Education program?

____

What do you hope to discuss during your **first visit** with the team at Taddle creek Diabetes Education Program? ____

Do you **want to make changes** to how you eat or your exercise? ☐ Yes ☐ No

If yes, what changes do you want to make? ____

____

Thank you for filling out our questionnaire!