Taddle Creek
Family Health Team

Diabetes Education Program

Intake Form

Name: _____ Date_____

Welcome to the Taddle Creek Diabetes Program! Thank you for taking the time to complete this form. **If you are not comfortable with any of the questions, you do not need to answer them. The information that you provide will help us to improve the quality of care, and also the plan for services and development. We want to provide respectful, inclusive and high quality care to clients with diverse backgrounds and needs.**

Please note that all of the information that you provide will be kept confidential. A report with recommendations from your Diabetes Educator will be sent to your family physician or nurse practitioner, and/or referring physician after each visit.

Is there anything specific that you want to discuss during your appointment (please select 2-3 priority topics)?

Diet/Nutrition ☐ Understanding Diabetes Diagnosis ☐ Monitoring Blood Sugar ☐

Physical Activity ☐ Medications ☐

Other: _____

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

Preferred first name (if different from what is on your health card/medical records): _____

Gender identity (refers to current gender which may be different from what is indicated on your health card/medical records):

Woman ☐ Man ☐ Trans Woman ☐

Trans Man ☐ Non-Binary ☐ Prefer not to answer ☐

Other: _____

Pronouns:

She/Her/Hers ☐ He/Him/His ☐ They/Them/Their/s ☐ No pronoun ☐

Other: _____

Do you live alone? | Yes | No |

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

_____

Are you currently employed?

Yes ☐ No ☐ Retired ☐ Self-employed ☐

Has there been any days in the last month when you or anyone in your family went hungry because you did not have enough money for food? | Yes | No |

Do you have any other financial concerns?

None ☐ Diabetes Supplies ☐ Medications ☐ Other ☐

_____

Do you have a drug plan?

None ☐ Private Drug Plan ☐ ODP (Senior's Drug Plan) ☐
Ontario Works ☐ ODSP (Long term Disability) ☐ Trillium ☐

Do you have any religious, family, or cultural practices that influence how you care for your health? E.g. fasting, dietary restrictions, etc. | Yes | No |

When (approximately) did you find out you have diabetes/prediabetes? _____

Family History

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

	Yes	No	Not sure
Diabetes			
Heart Disease			
High Blood Pressure			
High Cholesterol			

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

Increased Thirst ☐	Itchy Skin ☐	Headache ☐	Blurred vision ☐
Infections ☐	Tiredness ☐	Losing Weight ☐	Hearing problems ☐
Heart problems ☐	Stroke ☐	Need to urinate often ☐	Depression ☐
Cancer ☐	Arthritis ☐	Cholesterol problems ☐	Circulation problems ☐
Chronic pain ☐	Sleep Apnea ☐	Kidney Issues ☐	Urinary/bladder issues ☐
Eye/Vision issues ☐	Breathing issues ☐	Thyroid issues ☐	Sexual issues ☐
Bowel problems ☐	Numbness or tingling (in hands, feet etc.) ☐		

Other: _____

Have you had an ECG/EKG or Stress Test (to measure your heart function) in the past year?

Yes	No	Not sure

Do you smoke?	Yes	No
Do you drink alcohol?	Yes	No
Do you use social drugs (for example, marijuana, cocaine)?	Yes	No

Are you planning for pregnancy? | Yes | No

Do you have a history of gestational diabetes (Diabetes during pregnancy)? | Yes | No

Do you get an annual flu shot? | Yes | No

Have you ever had a pneumonia vaccine? | Yes | No

Social and Emotional Health Assessment

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

Little interest or pleasure in doing things

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

Feeling down, depressed or hopeless

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

Diabetes Self-Management

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

Do you have any symptoms that you think may be due to **low blood sugar** e.g., dizziness, sudden weakness, sudden shakiness, sudden sweating etc. | Yes | No

Are you physically active? | Yes | No | Advised not to by doctor

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

_____

Nutrition and Dietary History

Optional – What is your usual weight? (in kg or lb) _____

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

What is your height? _____ | Meters | Feet and Inches

In the last 6 months, my weight has

Gone up	Gone down	Stayed the same	Not sure

Have you ever seen a dietitian before? | Yes | No

Have you ever been involved in a diet/weight loss program before? (e.g., Weight Watchers, Atkin's diet, Dr. Bernstein, etc.) | Yes | No

Do you have any of the following food-related problems? (Please select all that apply)

Constipation ☐	Diarrhea ☐	Poor appetite ☐
Irritable bowel syndrome ☐	Crohn's disease or Colitis ☐	Chewing/Swallowing problems ☐
Celiac Disease ☐	Food allergies or sensitivities ☐	Diverticulosis ☐

Who prepares most of your meals at home?

Self ☐ Spouse ☐ Other family member ☐ Worker/Caregiver ☐

Approximately how many meals per week are from a restaurant (including take-out)?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

1 Or less — 16 Or more

Do you eat in response to emotions (like stress or boredom)?	Yes	No
Have you changed your eating habits in the past 6 months?	Yes	No

Please list all the types and amounts of fluids you drink during a typical day:

Do you want to make changes to your eating or exercise habits?	Yes	No
Is there anything else you would like to tell us about yourself?	Yes	No

_____

Please hand over this form to the Administrative Assistant before your appointment