



Class Date: _____

Assessment Date: _____

COMMUNITY DIABETES PROGRAM PARTICIPANT INFORMATION SHEET

ABOUT YOU

Name:	Today's Date:	
Date of Birth:	Age:	Gender:
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Other:		
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Other:		
Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please describe:		
What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:		
Who do you live with?		
How confident are you in filling out medical forms by yourself? <input type="checkbox"/> Extremely <input type="checkbox"/> Somewhat <input type="checkbox"/> Not at all		

REDUCING RISK

What type of diabetes do you have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational <input type="checkbox"/> Other:
When were you diagnosed with diabetes?
Have you had diabetes self-management education (DSMES) before? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE
How often do you have high blood sugar? <input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> Never
How often do you have low blood sugar? <input type="checkbox"/> Every day <input type="checkbox"/> A few times per week <input type="checkbox"/> A few times per month <input type="checkbox"/> Never



REDUCING RISK (CONTINUED)

Do you smoke? YES NO Do you drink alcohol? YES NO

In the past 12 months have you been to the emergency room because of diabetes?

YES NO

In the past 12 months have you been admitted to the hospital because of diabetes? YES NO

HEALTH HISTORY

Health History:

Do physical limitations interfere with your ability to manage your diabetes, get physical activity, or enjoy things that you like to do? YES NO

If YES, Hearing Vision Dexterity or use of hands Feet Pain Other:

Which of the following have you had or done in the past year?

Dilated eye exam Dental exam Had feet checked
 A1C Cholesterol Blood pressure check Stopped smoking

HEALTHY COPING

Who supports you in coping with the daily demands of managing diabetes?

Family Friends/Coworkers Support Group Diabetes Care & Education Specialist
 Health Care Professional Other:

Respond to the following by answering often true, sometimes true, or never true.

Diabetes gets in the way of the rest of my life:

Often True Sometimes True Never True

Feeling overwhelmed by taking care of my diabetes:

Often True Sometimes True Never True

Feeling that I am often failing with my diabetes care:

Often True Sometimes True Never True



BEING ACTIVE

On how many of the last SEVEN DAYS did you participate in at least 30 minutes of physical activity? (Total minutes of continuous activity, including walking): _____

How often do you participate in a specific exercise session (such as swimming, walking, biking) other than what you do around the house or as part of your work?

Every day A few times per week A few times per month Never

HEALTHY EATING

Do you follow a specific eating plan? YES NO

If yes, on how many of the last SEVEN DAYS did you follow your eating plan? _____

On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables? _____

On how many of the last SEVEN DAYS did you eat red meat or full-fat dairy foods? _____

TAKING MEDICATION

Do you take diabetes medication? YES NO

If yes, check all that apply: Pills Injections Insulin Supplements

On how many of the last SEVEN DAYS, did you take your medication and/or injections? _____

On how many of the last 7 days did you miss taking one or more of your medications or injections? _____

MONITORING

Do you check your blood sugar with a glucose meter or continuous glucose monitor (CGM)?

YES NO If YES, how often do you usually check your blood sugar? _____

Have you kept a food or activity log before? YES NO

PROBLEM SOLVING

Please rate your agreement with the following statements:

I know what to do when my blood sugar goes higher or lower than it should be.

YES NO UNSURE

I know when changes in my diabetes mean I should visit the doctor.

YES NO UNSURE

I know I can manage my diabetes so that it does not interfere with the things I want to do.

YES NO UNSURE



SOCIAL DETERMINANTS OF HEALTH

Respond to the following by answering often true, sometimes true, or never true.

Within the past 12 months, I 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 did not last and we didn't have money to get more.

Often True Sometimes True Never True

How often does this describe you?

I don't have enough money to pay my bills.

Often True Sometimes True Never True

I put off or neglect to go to the doctor because of distance or lack of transportation.

Often True Sometimes True Never True

I am worried or concerned that I may not have stable housing soon.

Often True Sometimes True Never True

I have a job. YES NO

DSMES PLAN

Please check all areas that you are most interested in learning about:

- What is Diabetes Healthy Coping Healthy Eating Being Active
 Taking Medications Reducing Risk Monitoring Problem Solving
 Other:

List goals, questions, or concerns for your DSMES Team: