



DIABETES/NUTRITION ASSESSMENT FORM

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

HEALTH BELIEFS & ATTITUDES/ CULTURAL FACTORS (Please explain any "Yes")

Any concerns regarding your health? No / Yes: \_\_Diabetes \_\_Cholesterol \_\_Weight \_\_Blood Pressure \_\_Kidney OTHER: \_\_\_\_\_

Any financial concerns affecting diabetes care? No / Yes: \_\_\_\_\_

Any religious practices/restrictions affecting diabetes care? No / Yes: \_\_\_\_\_

Any other information: \_\_\_\_\_

MEDICAL HISTORY

You consider your health to be: [ ] Good [ ] Fair [ ] Poor

Do you take any medicines at home? No / Yes (Please list dose and # times taken) [ ] See attached list or MD's note

\_\_\_\_\_

Do you take supplements: No / Yes: \_\_\_\_\_

Do you smoke? [ ] No [ ] Yes (# packs per day:\_\_\_\_) Use alcohol? [ ] No [ ] Yes (# drinks per day\_\_\_\_) or rarely

Table with 3 columns: Health Care in past 12 Months, # of Visits, Reason. Rows include Primary Doctor, Hospitalization / ER, Eye Doctor, Foot Doctor, Diabetes Education / Dietitian.

EXERCISE ROUTINE: Do you exercise? No / Yes (If yes, you started, \_\_\_ days/months/years ago) # of minutes: \_\_\_/time How often? \_\_\_ times per week Any physical limitations? Yes / No (If yes, explain: \_\_\_\_\_) Type of exercise: ( )Walking ( )Bike ( )Physical Therapy ( )Gym ( )Other cardio \_\_\_\_\_

PERSONAL BEHAVIOR GOALS: (CAN BE RELATED TO DIET, BLOOD SUGAR MONITORING, EXERCISE, MEDICATION, ETC)

1-My long term weight goal is to ( )decrease \_\_\_\_\_ lbs or ( )increase \_\_\_\_\_ lbs, or ( ) maintain weight

2-Other personal health goals of mine are to:

- ( ) Make changes in my diet. To meet this goal I will \_\_\_\_\_
( ) Increase my Physical activity. To meet this goal I will \_\_\_\_\_
( ) \_\_\_\_\_

BARRIERS TO LEARNING & SOCIOECONOMIC STATUS

Do you have any of the following that may make it difficult for you to learn? [ ] Vision loss [ ] Reading problems [ ] Hearing loss [ ] Emotional problems [ ] Language problems [ ] None [ ] \_\_\_\_\_

How do you learn best? (check one): [ ] Reading [ ] Listening [ ] Video [ ] Demonstration [ ] Any method

Primary Language: [ ]English [ ]Other \_\_\_\_\_

What do you do for a living? \_\_\_\_\_ Number of years of school completed: \_\_\_\_\_

SUPPORT SYSTEMS/ PSYCHOSOCIAL STATUS

[ ] Single [ ] Married [ ] Divorced [ ] Widowed Number people in household: \_\_\_\_\_ # Kids in household: \_\_\_\_\_

Primary emotional support person (circle one): self / spouse / parent / other \_\_\_\_\_

Any current major stresses? No / Yes (If yes, explain) \_\_\_\_\_

**NUTRITIONAL SCREENING / CURRENT EATING HABITS** Weight change in past 6 months? No / Yes: \_\_\_\_\_ lbs ( up / down)  
 Following any diet? No / Yes Diet History: Weight Watchers, Atkins, South Beach, Low Protein, \_\_\_\_\_

**\*You vary what you eat. Please mark/circle what you eat and drink on a TYPICAL/USUAL DAY:**

<b>BREAKFAST</b> Time:	<b>LUNCH</b> Time:	<b>DINNER</b> Time:	<b>SNACKS</b>
Skips? Yes # days/week: _____ Out / Home / both	Skips? Yes # days/week: _____ Out / Home / both	Skips? Yes # days/week: _____ Out / Home / both	<b>Mid Morning Snack:</b> (circle) None PB/Cheese Crackers Cookies Chips Crackers Fruits Nuts Juice Soda Cheese _____
( ) Cereal ( ) Oatmeal ( ) grits ( ) pancakes/Waffles ( ) Toast ( ) Butter ( ) Margarine ( ) Jelly ( ) Eggs ( ) Bacon ( ) Sausage ( ) Milk: skim / 1% / 2% / whole ( ) Fruit ( ) Yogurt ( ) Fast Food: What you order?	( ) Sandwiches: cheese turkey ham tuna salami chicken hamburger ( ) Mayo ( ) Chips ( ) Soup: Canned? ( ) Leftovers ( ) Frozen meals: Brand: ( ) Full meal: ( ) Chicken ( ) Beef ( ) Pork ( ) Fish ( ) Rice ( ) Potato ( ) Pasta/Noodle ( ) Peas ( ) Corn ( ) Beans ( ) Cooked Vegetables ( ) Salad ( ) Salads Dressing ( ) Sour Cream ( ) Fruit ( ) Cookies ( ) Dessert Drink:	( ) Chicken ( ) Beef ( ) Pork ( ) Fish ( Fried Baked Grilled Boiled ) ( ) Rice ( ) Potato ( ) Pasta/Noodle ( ) Peas ( ) Corn ( ) Beans ( ) Cooked Vegetables ( ) Salad ( ) Salads Dressing ( ) Sour Cream ( ) Gravy ( ) Butter ( ) Margarine ( ) FROZEN MEALS ( ) SANDWICHES ( ) _____ ( ) Dessert ( ) Fruit ( ) Wine/Beer Drink:	<b>Afternoon Snack:</b> (circle) None PB/Cheese Crackers Cookies Chips Crackers Fruits Nuts Juice Soda Cheese Ice Cream <b>Bed Time Snack:</b> (circle) None PB/Cheese Crackers Cookies Chips Crackers Fruits Nuts Juice Soda Cheese Ice cream
Drink:	Drink:	Drink:	

Do you consume: \_\_\_ Juice \_\_\_ Regular Soda \_\_\_ Sweet Tea \_\_\_ Nuts \_\_\_ Cookies \_\_\_ Ice Cream \_\_\_ Cheese \_\_\_ Candy  
 \_\_\_ Frozen Meals \_\_\_ Canned Soup/Vegetables \_\_\_ Chocolate \_\_\_ Chips \_\_\_ Fast Food \_\_\_ Fries \_\_\_ Fried foods

How often do you eat out? \_\_\_\_\_ Times daily / weekly / monthly Who cooks? \_\_\_ Self \_\_\_ Spouse \_\_\_ Other

Do you currently have problem with? Chewing: Yes / No Swallowing: Yes / No Lack of Appetite: Yes / No  
 3 or more Food Allergies: Yes / No Please explain any "Yes": \_\_\_\_\_

**DIABETES ASSESSMENT:** If you do NOT have diabetes skip this section. ( ) I have Pre-diabetes

How long have you has diabetes? \_\_\_\_\_ days / months / years What type: ( ) Type 1 ( ) Type 2 ( ) Don't know

What do you hope to learn about diabetes? [ ] diet [ ] blood sugar monitoring [ ] \_\_\_\_\_

Do you have any of the following problems (caused by diabetes)? *Circle ones that apply:*

Kidney Failure Heart Disease/Stroke Eye Problem Foot Problem Frequent Infections Sexual Problem Denial  
 Depression High Blood Pressure Gastroparesis Anger Stress Other: \_\_\_\_\_

Do you take diabetes medication?	Do you test your Blood sugar?	Do you have glucose over 200?	Do you have glucose below 70?	Do you test urine for ketones?
YES / NO	YES / NO	YES / NO	YES / NO	YES / NO
Which ones / How often	How often? Most recent fasting glucose: _____ 2hrs post meals: _____	If yes: ( ) Daily ( ) Rarely ( ) _____	If yes: ( ) Daily ( ) Rarely ( ) _____	

*I certify that the above information supplied by me is true and complete to the best of my knowledge.  
 The above information will be reassessed with each patient follow up visit. Changes will be noted on "Follow up sheet".*

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Clinician Signature Patricia M-Cali, MS, RD/LD, CDE

\_\_\_\_\_  
 Date

