Luminis Health

Self-Assessment
Diabetes & Nutrition Management

Would you like help completing this form? □ Yes We can help call 301-552-8661

Patient Registration: Please complete all sections of the form with as much information as possible.

Name: ____ Date: ________________________

Address: ____

City: ____ State: _________________ Zip: ______________

Home: ______________________________ Work: _________________________ Cell: ________________________

Date of Birth: ____________________ Age: __________________ Sex/Gender: □ Female □ Male □ Other

Racial background: □ American Indian/Alaska Native □ Asian □ Black/African American □ Middle-Eastern □ Native Hawaiian/Pacific Islander □ White/Caucasian

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Country of Origin: ________________________ What is your language preference: □ English □ Other: ___________

Do you have cultural practices or religious beliefs that influence how you care for your health? □ Yes □ No
If yes, please describe: ____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other Number of people at home: ___________
How are they related to you (check all that apply): □ Spouse □ Family □ Friends □ Significant Other □ Roommate □ Other

Highest grade of school you completed: □ High School/GED □ Some College/Degree □ Some Graduate/Degree □ Other

Employed: □ Yes □ No □ Retired □ Disabled □ Other Employer: ____

Emergency Contact: ____________________________ Relationship:_____________ Phone: ____________________

Billing Information/Responsible Party:

Subscriber: ________________________ Relationship to patient:___________ Subscriber Date of Birth: _________

Primary Insurance: _____________________________ Policy ID#:______________________ Group: ____________

Secondary Insurance: _____________________________ Policy ID#:______________________ Group: __________

Provider:

How did you hear about our program: □ Doctor/Provider □ Family/Friend □ Internet □ Hospital □ Other ________

Primary Care Provider: ________________________________ Phone:___________________ Fax: ______________

Reason for Visit: ____

What is your main goal for the education session(s): ____

Height: ______ Weight: ______ Glucose: ______

Pregnancy and Fertility: (Females)

Are you: □ Pre-menopausal □ Menopausal □ Post-Menopausal □ N/A
Are you pregnant? □ Yes If yes, Due date: ________ □ No Are you planning to become pregnant? □ Yes □ No
Have you been pregnant before? □ Yes □ No Do you have children □ Yes Ages: _____________ □ No
Are you Breastfeeding? □ Yes □ No If yes, how many months:______ Are you using birth control? □ Yes □ No

Medical History: please indicate medical conditions you have had: (select all that apply)

□ Asthma	□ Cancer	□ Dental disease	□ Depression
□ High Blood Pressure	□ Heart Attack	□ Gastro paresis	□ Kidney disease
□ High Cholesterol	□ Diabetes 1 or 2	□ Sexual problems	□ Thyroid
□ Numbness/tingling/ loss of feeling in feet	□ Retinopathy	□ Stroke	□ Eye condition
□ Gestational diabetes	□ Nerve changes	□ Hearing loss	□ Bowel problems
□ Pre-diabetes	□ Weight gain	□ Weight loss	□ Urinary problems
□ Skin problems	□ PCOS	□ Arthritis	□ Skin problems
□ Other:________________________________			

List all medications you take, include dose and if 2 times a day or more – OR – attach a current medication list:
____
____
____
____
____
____

List multivitamins, herbs or supplements you use: ____

What allergies do you have (to medication, food or other): ____________________________________

What surgeries have you had: ____

In the last 12 months, how many times have you:
Gone to an Emergency Room or Urgent Care □ None □ Once □ 2-3 times □ More
Been admitted to a Hospital □ None □ Once □ 2-3 times □ More
Was the ER/Urgent care visit or hospital admission diabetes related: □ Yes □ No

In the past 3 months have you fallen? □ Yes □ No Do you have chronic pain? □ No □ Yes

In the past 6 months has your weight changed? □ No □ Yes If yes: □ Weight gain □ Weight loss
What is your usual Weight? ___________________________ Height ________________________

What medicines have you used to lose weight? ____

What diets have you used to lose weight? ____

Do you have any difficulty with: □ Hearing □ Seeing □ Reading □ Speaking
□ Chewing □ Swallowing □ Tasting □ Smelling

How many packs of cigarettes do you smoke per day: □ I don't smoke □ 0 - 1 pack □ 1 pack □ 1-2 packs □ Other: ______
How often do you use recreational drugs: □ I don't use drugs □ daily □ weekly □ monthly □ Other: _______________

Meal Pattern and Routine:

What best describes the way you eat (select all that apply):
□ Limit/Count carbohydrates □ Reduced fat □ Count calories □ Weigh and measure food □ Reduced salt □ Eat what I want
□ Use exchange lists □ often skip 1 or 2 meals □ snack or "graze" all day □ follow a meal plan □ Other: ________________
What food/beverage restrictions do you have? □ None □ Fluid □ Other ___________________________________
Do you follow a meal plan? □ No □ Yes If yes, please describe: ____

How often do you use this meal plan? □ Never □ Seldom □ Sometimes □ Usually □ Always □ Other: ____________

How many meals do you eat per day: ____________ How many snacks do you have per day: ________________

Give a sample of your meals and snacks in the past 24-hours or on a typical day (indicate if a meal or snack):
Time: ______ Meal/Snack: ____
Time: ______ Meal/Snack: ____
Time: ______ Meal/Snack: ____
Time: ______ Meal/Snack: ____
Time: ______ Meal/Snack: ____

What beverages do you drink: ____

What alcoholic beverages do you drink? □ None □ List: ____
How many drinks do you have when you drink? _____________

Do you read and use food labels? □ Yes □ No If yes, how often: □ Usually □ Sometimes □ Rarely

Do you shop for your food? □ Yes □ No if No, who does: ____
Who prepares your meals? □ I do □ Other: ____

How many meals do you eat out each week (from a restaurant or fast food)? _____ Where? __________________

When do you eat fried food? □ Daily □ 3 or more times a week □ 1-2 times a week □ 1-2 times a month □ Rarely □ I don't

In the past 3 months how often were you physically active at a moderate pace: (you can talk but not sing at that pace)
□ Daily □ 3-5 times a week □ 1-2 times a week □ A few times a month □ Other: ____________________________

How do you like to learn new things: □ Reading □ Visual □ Demonstration □ Hands-on activity □ Instruction
Which learning environment do you prefer: □ Individual session □ Group session □ Both are okay

Diabetes Care and Management Routine: **(If you do not have diabetes please skip to last page)**

What type of diabetes do you have? □ Type 1 □ Type 2 □ Pre-Diabetes □ Gestational Diabetes □ Don't know
Year/Age of diabetes diagnoses: ________ /_______ Relatives with diabetes: ______________________________

Do you take diabetes medications: □ Yes □ No
When do you take your medications: □ Breakfast □ Lunch □ Dinner □ Bedtime □ 2 hours after meals □ Other times
How often might you miss taking your medications? □ Daily □ 3 times a week □ 1-2 times a week □ Rare □ None
Which are a problem for you: □ forget to take it □ side effects □ take wrong dose □ bruise/lump at injection site □ Cost

Do you check your blood sugar: □ Yes □ No Name of Meter: ____

Do you have adequate supplies to check your blood sugar: □ Yes □ No

Diabetes Care and Management cont.

When do you test your blood sugar: Before □ Breakfast □ Lunch □ Dinner □ Bedtime □ 2 hours after meals □ Other
Range of BS before breakfast: ______________________________
Range of BS before lunch: ______________________________
Range of BS before dinner: ______________________________
Range of BS 2 hours after a meal: ______________________________
What is your target blood sugar range: ______________________________
Do you keep a record of your blood sugars: □ Yes □ No If yes, □ Logbook □ Phone app □ Meter Memory □ Other: ____
Do you test your urine or blood for ketones: □ Yes □ No

In the last month, how often was blood sugar 70 mg/dl or lower? □ Never □ Once □ 1 or more times a week □ Other
What are your symptoms at 70 mg/dl or lower? ______________________________
How do you treat a low blood sugar? ______________________________

Can you tell when your blood sugar is too high? □ Yes □ No What symptoms do you have? __________________
How often was blood sugar 130 mg/dl or higher before meals? □ Never □ Once □ 1 or more/ week □ Daily □ Other
How do you treat a high blood sugar?______________________________

Which of the following have you had in the last 12 months? (check all that apply)
□ Dilated eye exam □ Urine test for protein □ Foot exam-self □ Foot exam-provider □ Dental exam
□ Blood pressure check □ Weight checked □ Blood Cholesterol test □ A1C test □ Flu / Pneumonia shot
□ Other: ______________________________

Have you been instructed on how to take care of your diabetes before today? □ Yes □ No When: ___________
In your own words, what is diabetes? ______________________________

Please state whether you agree, are neutral or disagree with the following statements:

Statement	
I feel good about my general health	□agree □neutral □disagree
My diabetes interferes with other aspects of my life	□agree □neutral □disagree
My level of stress is high	□agree □neutral □disagree
I have some control over whether I get diabetes complications or not	□agree □neutral □disagree
I struggle with making changes in my life to care for my diabetes:	□agree □neutral □disagree

How do you handle stress? ______________________________

From whom do you get support to manage and cope with your diabetes?
□ Spouse □Family □ Co-workers □ Providers □ Support group or diabetes buddy □ Social media □ No one □ Other:

During the past month, have you often been bothered by:

Feeling down, depressed or hopeless	□ Yes □ No
Having little interest or pleasure in doing things	□ Yes □ No

What concerns you most about your diabetes? ______________________________

Which of the following gets in the way of managing your diabetes: (check all that apply)
□ Nothing □ Money □ Health problems □ Stress □ Work □ Uncertain what to do
□ Lack of time □ Emotions □ Family □ Friends □ feel tired □ Feels like nothing is working
□ Not ready to make changes right now □ Other: ______________________________

Signature: ______________________________ Date: ______________________

Education Needs/Education Plan: □Diabetes Disease Process □Nutritional Management □Physical Activity □ Medications □Monitoring □Preventing Acute Complications □ Preventing Chronic Complications □Behavior Change □Psychosocial Adjustment

Clinician Signature: ____ Date: ____________________