**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Daily Activities**:

1- Not at all, 2-Slightly, 3-Moderatly, 4-Quite a bit

In the last two weeks has your diabetes….

1. Interfered with your normal social activities? 1 2 3 4

(Family, friends, and neighbors)

2. interfered with your hobbies or recreational activities? 1 2 3 4

3. Interfered with your household chores? 1 2 3 4

4. Interfered with your errands or shopping? 1 2 3 4

5. Do you need assistance with simple daily tasks? Yes No

 If yes, circle the following if they apply.

Eating (1) Bathing (1) Cooking(1) Dressing(1) Toileting(1) Getting in/out of bed (1)

6. Do you receive assistance at home? Yes No

 If yes, circle one of the following:

HHA (1) VNA (1) PT (1) OT (1) Speech Therapy (1) MOW(1)

TOTAL SCORE Daily Activities\_\_\_\_\_\_\_\_\_ /28

**Glucose testing/Medications:**

1- Very, 2- Moderately, 3- Slightly, 4-Not at all

1. Do you use a glucometer? Yes(1) No (2)

If yes, what brand? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the last week have you tested your glucose? Yes(1) No (2)
2. On the days that you tested, how many times a day did you test? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ < daily (2) 1 -2xday (1) > 2x day (0)
3. How satisfied are you with your overall blood glucose? 1 2 3 4
4. What is your target range? \_\_\_\_\_\_\_\_\_\_\_\_\_ Do not know (1)
5. What was your last A1C? \_\_\_\_\_\_\_\_\_\_\_\_ <7.0 (0) 7-8 (1) 8-9 (2) >9.0 (3)
6. Do you take medications to manage your diabetes? Yes(2) No(1)

If yes what kind (oral/injectable)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 8. How satisfied are you with managing your medication? 1 2 3 4

 9. How often in a week do you miss taking medication as prescribed? None (0) Few (1) Frequently (2)

 TOTAL SCORE Glucose testing/Medications\_\_\_\_\_\_\_\_\_\_\_/22

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physical activities/Diet:**

On an average week how much time do you spend for the entire week with the following activities?

0-None, 1- Less than 30mins/wk., 2- 30-60 mins/wk., 3-1-3hrs/wk., 4- more than 3 hrs. /wk.

1. Stretching or strength exercising(Range of motion, using weights): 0 1 2 3 4
2. Walking for exercise: 0 1 2 3 4
3. Swimming: 0 1 2 3 4
4. Cycling(Stationary or exercise bikes): 0 1 2 3 4
5. Tai Chi/Yoga 0 1 2 3 4
6. Other aerobic(Kayaking, Skiing machine, Stairmaster) 0 1 2 3 4

On average in the last week have you:

1. Eaten breakfast when you woke up? Yes No (1)
2. Have one or more of the following for breakfast, ( circle) Yes No (2)

Milk Eggs Cheese Meat/Poultry/Fish Yogurt Beans

1. Eaten lunch? Yes No (1)
2. Eaten dinner? Yes No (1)
3. Had a healthy snack in between meals? Yes No (1)

Do you have trouble?

1. Planning healthy meals? Yes (1) No
2. Knowing portion sizes? Yes (1) No
3. Reading labels on food packages? Yes (1) No
4. Eating healthy while in the presence of others that are non-diabetics? Yes (1) No TOTAL SCORE Physical Activity/Diet \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/34

**Health**

1-Very , 2-Moderately, 3- Slightly, 4- Not at all

How satisfied are you with your overall health? 1 2 3 4

In the last 6 months have you…?

1. Have you seen your primary care physician? Yes No (1)
2. Have you had to go to the emergency room in the past 6 months? Yes (1) No
3. Have you had to say overnight in a hospital in the past 6 months? Yes (2) No
4. Of the times you have been admitted how many resulted in you being transferred to a skilled nursing facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 admit (1) 2 or more admits (3)

In the last year have you…?

1. Had an eye exam? Yes No (1)
2. Have you seen a podiatrist? Yes No (1)
3. Have you seen Nutrition/Dietician? Yes No (1)
4. Have you seen Diabetes Educator? Yes No (1)
5. Have you seen an Endocrinologist? Yes No (1)

 TOTAL SCORE Health \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/16

SCORING:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Patient Score** | **Minimal Needs Identified** | **Moderate Needs Identified** | **Maximum Needs Identified** |
| **Daily Activities** |  | 0-9 | 10-20 | 21-28 |
| **Glucose testing/Medications** |  | 0-7 | 8-16 | 17-22 |
| **Physical Activity/Diet** |  | 0-10 | 11-22 | 23-34 |
| **Health**  |  | 0-5 | 6-10 | 11-16 |
| **TOTAL all areas** |  | 0-33 | 34-66 | 67-100 |