Date:       Preferred name:

# To make the most of your session, we ask that you complete this form. The information you provide will be kept confidential.

**HEALTH HISTORY**

When were you told that you have diabetes or elevated blood sugars?

What were your symptoms?

Does anyone in your family have diabetes?  Yes  No  Don’t know If yes, who?

Are you being treated for any other health problems, i.e., arthritis, heart problems, depression, other?

Have you received education on healthy lifestyle or control of blood sugar in the past, either by self study or attending an education session?  Yes  No  Don’t know

Do you have any difficulty with the following?  Seeing  Hearing  Walking  Speaking English Reading English

Other, please specify:

# MEDICATIONS

Please list or attach a copy of prescription medications and/or insulin.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Medication / Insulin** | **Dosage (How much) and time taken?** | | | |
| **Breakfast** | **Lunch** | **Dinner** | **Bedtime** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Do you usually take your medications as prescribed?  Yes  No  Don’t know

Please list any **non-prescription** (over the counter) medications such as vitamin/mineral supplements, aspirin, herbal supplements.)

# FOR STAFF USE ONLY:

# 

**BLOOD GLUCOSE MONITORING**

Do you test your own blood sugar?  Yes  No  Don’t know If no, please go to the **Lifestyle section.**

# If yes, please bring your meter & results with you.

If yes, what time(s) do you test?

How many days per week?

Have you experienced any symptoms of low blood sugar?  Yes  No  Don’t know

If yes, how do you treat this?

# LIFESTYLE

**PERSONAL HISTORY**

Do you live alone  Yes  No  Don’t know

What country were you born in?

What language do you speak at home?

# EMPLOYMENT:

Do you currently work?  Yes  No  Don’t know What is your occupation?

Do you work  Full Time  Part Time  Casual  Seasonal

Shifts worked  Day  Evening  Night  Variable

# ACTIVITY/EXERCISE

How often do you exercise?  Not often  Regularly Number of days a week

What do you do for exercise?

Have you changed your amount of exercise recently?  More  Less  the Same

# HOBBIES & INTERESTS

What are your hobbies and interests?

# FOOD HISTORY

Please indicate the meals and snacks that you usually eat (at least 4 times a week) eat, and at what time you eat them.

|  |  |  |  |
| --- | --- | --- | --- |
| Breakfast | Time | Mid Afternoon | Time |
| Mid-Morning | Time | Dinner | Time |
| Lunch | Time | Evening | Time |

Have you changed your eating habits recently?  Yes  No  Don’t know If yes, please describe

Do you follow any particular diet?  Yes  No  Don’t know If yes, please describe

Do you have food allergies  Yes  No  Don’t know If yes, what are they

# FOR STAFF USE ONLY:

**ALCOHOL**

Do you drink alcoholic beverages  Yes  No  Don’t know

How many days per week       How many drinks do you have per day

Is this a recent change?  Yes, more  Yes, less  No

# TOBACCO USE

Have you used any form of tobacco in the past 6 months?  Yes  No  Don’t know

Other substance use?

# CONCERNS

Please check any concerns that might interfere with your taking care of your health:

Not ready to change  Family  Tobacco use  Finances

Employment  Physical health  Alcohol and//or drug use

Lack of support  Stressful events

Do you have any comments about your concerns?

# SELF MANAGEMENT

Are your blood sugars in the recommended range?  Yes  No  Don’t know

Is your blood pressure in the recommended range?  Yes  No  Don’t know

Are your cholesterol levels in the recommended range?  Yes  No  Don’t know

# PERSONAL GOALS

What changes have you made to manage your health?

What changes are you thinking about?

What would you like to learn or discuss at this session?

FOR STAFF USE ONLY:

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