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:

VCH.CO.WCHC.0019 | JUNE.2015 Page 3 of 3