

## Pediatric Diabetes Self-Management Assessment Form

Please answer the questions by marking appropriate boxes or writing in accurate information in provided spaces. If you are unsure about how to answer a question, please give the best answer you can.

### DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_

Today's date: \_\_\_\_\_ What is your age? \_\_\_\_\_ What is your Gender?  Female  Male

#### What is your Race/Ethnicity? (mark all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Asian                                     |
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |
| <input type="checkbox"/> White or Caucasian               | <input type="checkbox"/> Middle Eastern                            |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Chinese                                   |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Japanese                                  |
| <input type="checkbox"/> Korean                           | <input type="checkbox"/> Vietnamese                                |
| <input type="checkbox"/> Guamanian or Chamorro            | <input type="checkbox"/> Samoan                                    |
| <input type="checkbox"/> Other _____                      |  |

Are you Hispanic (Latino, Mexican, Spanish)?  Yes  No

Are there other care givers in your home?  Yes  No Explain: \_\_\_\_\_

#### Education

What grade are you in? \_\_\_\_\_ Day care/after school care?  Yes  No \_\_\_\_\_

Which school do you attend? \_\_\_\_\_

How do you learn best?  reading  class  films  computer  participation/demonstration

Do you have a job?  Yes  No

Type of work: \_\_\_\_\_ Typical hours: \_\_\_\_\_

#### Do you have any physical limitations? (mark all that apply)

- Hearing problems  Vision loss (not corrected by glasses or contacts)  
 Problems with use of hands

#### What is your primary language?

English  Spanish  Other, please list: \_\_\_\_\_

To help us focus on diabetes issues which concern you most, please identify any issues that are especially important to you:

- |  |  |
|--|--|
| <input type="checkbox"/> Eating healthfully and following my food plan | <input type="checkbox"/> Becoming and staying physically active                            |
| <input type="checkbox"/> Testing my blood sugar regularly              | <input type="checkbox"/> Taking diabetes medication as prescribed, if any                  |
| <input type="checkbox"/> Balancing stress                              | <input type="checkbox"/> Seeking support when I need it                                    |
| <input type="checkbox"/> Preventing complications                      | <input type="checkbox"/> Problem solving: dealing with challenges associated with diabetes |
| <input type="checkbox"/> Managing school schedule and educating staff  |  |
| <input type="checkbox"/> Others _____                                  |  |

Is it difficult for you to pay for diabetes care?  no  yes (explain) \_\_\_\_\_

Are you aware of diabetes community resources?  no  yes

**HEALTH HISTORY**

**General Health Issues:** (check all that apply and explain)

- high blood pressure
- heart disease
- frequent infections
- high cholesterol
- thyroid disease
- ADD/ADHD
- frequent nausea, vomiting, constipation, diarrhea \_\_\_\_\_
- other health problems \_\_\_\_\_
- asthma
- mental health \_\_\_\_\_
- sleep apnea
- eye or vision problems (explain) \_\_\_\_\_
- numbness/pain/tingling of hands/feet (explain) \_\_\_\_\_
- Gum disease
- Celiac disease
- Learning disability
- foot problems (explain) \_\_\_\_\_
- kidney/bladder problems (explain) \_\_\_\_\_

What infections have you had within the last 3 months (mark all that apply)

- head, throat, chest
- wound
- vaginal (yeast)
- bladder
- none

**DIABETES HEALTH STATUS**

What year were you told you had diabetes? \_\_\_\_\_

Is your diabetes:  Type 1  Type 2  not sure

Have you attended a diabetes education program?  No  Yes

Do you have family history of diabetes?  No  Yes

How many times have you been seen in the emergency room? \_\_\_\_\_

How many times have you been in the hospital? \_\_\_\_\_ Reason? \_\_\_\_\_

**ACTIVITY:**

What type of exercise do you do?  walk  bike  aerobic machine  swim  sports  active job  
 other \_\_\_\_\_

How often do you currently exercise? (times/week)  0  1-2  3-4  5-6  >6

How long? (minutes/day)  0  1-15  16-30  31-45  46-60  >60

Do you have PE at school?  Yes  No What time: \_\_\_\_\_

Do you adjust insulin and/or diet for activity?  Yes  No If yes, how: \_\_\_\_\_

**EATING HISTORY: school days:**

Usual time you get up \_\_\_\_\_ go to bed \_\_\_\_\_

Meal times: breakfast \_\_\_\_\_ lunch \_\_\_\_\_ dinner \_\_\_\_\_

a.m. snack \_\_\_\_\_ afternoon snack \_\_\_\_\_ p.m. snack \_\_\_\_\_

**EATING HISTORY: weekend days:**

Usual time you get up \_\_\_\_\_ go to bed \_\_\_\_\_

Meal times: breakfast \_\_\_\_\_ lunch \_\_\_\_\_ dinner \_\_\_\_\_

a.m. snack \_\_\_\_\_ afternoon snack \_\_\_\_\_ p.m. snack \_\_\_\_\_

PATIENT IDENTIFICATION

**INOVA HEALTH SYSTEM  
PEDIATRIC DIABETES  
SELF-MANAGEMENT ASSESSMENT**

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In the past month, have you:  lost weight  gained weight  # lbs lost/gained: \_\_\_\_\_  No change

If you lost weight, was it:  intentional  unintentional

Have you ever adjusted your insulin to influence your body weight?  Yes  No

Do you have any diet restrictions? (allergies/intolerances, religious, vegetarian) \_\_\_\_\_

Is it hard to control what you eat?  Yes  No

Do you skip meals:  Yes  No

How many times per week do you eat out?  0-1  2-4  5-8  daily

Do you eat school lunch?  Yes  No  sometimes

How often do you eat the following foods:

- |                   |                                |                                 |                                    |                                |
|-------------------|--------------------------------|---------------------------------|------------------------------------|--------------------------------|
| Fruit             | <input type="checkbox"/> never | <input type="checkbox"/> rarely | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| Vegetable         | <input type="checkbox"/> never | <input type="checkbox"/> rarely | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| Milk              | <input type="checkbox"/> never | <input type="checkbox"/> rarely | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| Soda/fruit drinks | <input type="checkbox"/> never | <input type="checkbox"/> rarely | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| Water             | <input type="checkbox"/> never | <input type="checkbox"/> rarely | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |

### **MEDICATIONS**

Drug allergies:  No  Yes (please list) \_\_\_\_\_

<b>MEDICATION AND DOSE</b> (include prescriptions, vitamins, herbals, and over the counter)	<b>TIMES TAKEN</b>	<b>DATE STARTED</b>
Glucagon <input type="checkbox"/> Yes <input type="checkbox"/> No		

### **MONITORING:**

Are you testing your blood sugars at home?  no  yes

Name of meter \_\_\_\_\_

How many days a **week** do you usually test?  none  1-2 days/week  3-5 days/week  daily  occasionally

How many times a **day** do you usually test?  1-2 times/day  3-4 times/day  more than 4

What blood sugar range do you try to achieve? \_\_\_\_\_

Do you have low blood sugar reactions?  no  yes symptoms \_\_\_\_\_

If so, what time of day?  morning  afternoon  evening  overnight  varies

# of times per week:  0  1-2  3-4  >4  Other \_\_\_\_\_

Where do you test your sugar at school? \_\_\_\_\_

What do you carry to treat a low sugar? \_\_\_\_\_ (describe)

Have you ever needed help to treat a low sugar?

Explain: \_\_\_\_\_

Do you wear diabetes identification?  no  yes \_\_\_\_\_ (describe)

What was the result of your last Hemoglobin A1C test? \_\_\_\_\_ % Date: \_\_\_\_\_  Unsure

**WELLNESS / LIFESTYLE:**

Tobacco use: type: cigarettes / cigars / tobacco  never  quit (year \_\_\_\_\_)  yes (amount/day \_\_\_\_\_)  
 Recreational drug use:  never  quit (year \_\_\_\_\_)  yes (amount/day \_\_\_\_\_)  
 Alcohol use:  never  quit (year \_\_\_\_\_)  yes (amount/day \_\_\_\_\_)  
 Indicate date of:  
 Last dilated eye exam \_\_\_\_\_ Flu shot \_\_\_\_\_  
 Last foot exam \_\_\_\_\_

**Sexual Activity:** (check if applies)

pregnant  using contraception  sexually active

**Do you have any pain because of your diabetes today?**  No  Yes If Yes, where is the pain?

If yes, please rank your pain on a scale of:



List any medications or treatment you use to take care of the pain \_\_\_\_\_  
 Is your pain relieved with medication or other treatment?  No  Yes

**As health care providers, we are concerned about the safety of our patients so we ask every patient:**

Do you feel safe at home?  Yes  No  
 Do you feel safe in your neighborhood?  Yes  No (If no, you may discuss this with the diabetes educator)

How often do you need to have someone help you with instructions, pamphlets, or other written material from your doctor or pharmacy?  
 never  rarely  sometimes  often  always

**LIVING WITH DIABETES**

**Please tell us how you feel about your diabetes** (mark one answer for each question)

	A Lot	Some	A Little	Not at All
How sure are you that you can manage your diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much do you feel your family/friends support your efforts for diabetes control? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does your medical team help with your diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does diabetes interfere with your job, school, or daily activities? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does your diabetes seem out of control? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much are you afraid you will get complications? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel overwhelmed by your diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How much does diabetes interfere with your relationships? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**During the past 2 weeks:**

Have you often been bothered by feeling down, depressed, or hopeless? .....

Have you often been bothered by little interest or pleasure in doing things? .....

Patient/Caregiver Signature \_\_\_\_\_ Date \_\_\_\_\_

Date reviewed: \_\_\_\_\_ Educator Signature: \_\_\_\_\_