Welcome

to the Diabetes & Cardiovascular Wellness Clinic!

Please help *us* help *you* by sharing your history and goals:

Please mark all of the following health conditions for which you are seeking care:

- ☐ Prevention of diabetes and/or heart disease
- ☐ Type 2 diabetes
- ☐ Type 1 diabetes
- ☐ High blood pressure
- ☐ High blood cholesterol
- ☐ Heart failure
- ☐ Recent heart attack
- ☐ Recent stroke
- ☐ Recent surgery, i.e., bypass, angioplasty, etc.
- ☐ Kidney disease
- ☐ Palpitations/arrhythmia
- ☐ Erectile dysfunction (men)
- ☐ Other: ____________________

What goals do you have for your care here? (Mark all that apply.)

- ☐ Improve my health
- ☐ Reduce my symptoms
- ☐ Assess my risk for diabetes and/or heart disease
- ☐ Develop a long-term plan or program for my health condition
- ☐ Receive advice on diet
- ☐ Receive advice on exercise
- ☐ Receive advice on stress management
- ☐ Receive advice on dietary supplements/natural products
- ☐ Receive advice on other complementary medicine approaches to my condition
- ☐ Other: ____

____

____

What type of health care are you seeking? (Mark all that apply.)

- ☐ One time advice for my health condition
- ☐ On-going management of my health condition
- ☐ Primary management of my health condition
- ☐ Adjunctive care for my health condition
- ☐ I don't really know. I am interested in guidance, information or clarification about what I'm currently doing now for my health condition.

How do you like to learn? (Mark all that apply.)

- ☐ Reading
- ☐ Doing things
- ☐ Listening
- ☐ One on one
- ☐ Slides/Videos
- ☐ Have someone show me
- ☐ With a group
- ☐ Talking/Asking questions

Please share some of your heart health history:

Question			
1. Do you have family history of diabetes or heart disease (i.e., early in life or death from)?		Yes	No
2. Have you been diagnosed with diabetes?	(If yes, how long ago? ___ years)	Yes	No
3. Have you smoked more then ten cigarettes in your life?		Yes	No
4. Do you smoke currently?		Yes	No
5. Do you get at least 150 minutes of physical activity per week?		Yes	No
6. Do you eat at least 5-7 servings of fruits/vegetables per day?		Yes	No
7. Do you eat fish at least 2x per week, or take a fish oil supplement?		Yes	No
8. Do you consume alcohol?	(If yes, # drinks/week? ______)	Yes	No

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Please share some information about your quality of life:

1. In general, would you say your health is? Mark: Excellent Very Good Good Fair Poor

2. Does your **health now limit you** in these activities during a typical day? If so, how much?

2a. **Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf? Mark:

Yes, a lot limited Yes, a little limited No, not limited at all

2b. Climbing **several** flights of stairs? Mark:

Yes, a lot limited Yes, a little limited No, not limited at all

3. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

3a. **Accomplished less** then you would like? Mark:

All of the time Most of the time Some of the time A little of the time None of the time

3b. Were limited in the **kind** of work or other activities? Mark:

All of the time Most of the time Some of the time A little of the time None of the time

4. During the **past 4 weeks**, how much of the time have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

4a. **Accomplished less** then you would like? Mark:

All of the time Most of the time Some of the time A little of the time None of the time

4b. Were limited in the **kind** of work or other activities? Mark:

All of the time Most of the time Some of the time A little of the time None of the time

5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)? Mark:

Not at all A little bit Moderately Quite a bit Extremely

6. These questions are about how you feel and how things have been with you during the **past 4 weeks.** For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**: 6a. Have you felt calm and peaceful? Mark:

All of the time Most of the time Some of the time A little of the time None of the time

6b. Did you have a lot of energy? Mark:

All of the time Most of the time Some of the time A little of the time None of the time

6c. Have you felt downhearted and depressed? Mark:

All of the time Most of the time Some of the time A little of the time None of the time

7. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)? Mark:

All of the time Most of the time Some of the time A little of the time None of the time

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Please share some of your emotional health history:

1. How often do you feel stress at home (feeling irritable, filled with anxiety, or have sleep problems as a result of conditions at home)?

   Never   Some periods   Several periods   Permanent

2. How often do you feel stress at work (feeling irritable, filled with anxiety, or have sleep problems as a result of conditions at work)?

   Never   Some periods   Several periods   Permanent

3. How would you describe your financial stress?

   Little or none   Moderate   High/severe   None of the time

4. Have you had any of the major traumatic life events within the past year: marital separation or divorce, loss of job or retirement, loss of crop or business failure, death or major illness of a close family member, death of a spouse, or other major stress?

   Yes   No

5. Using the following scale, please the number representing how much you agree or disagree with the following statements:

   0=Don't agree at all   3=Neither agree or disagree   6=Strongly agree

Statement							
a. At home, I feel I have control over what happens in most situations:	0	1	2	3	4	5	6
b. I feel that what happens in my life is often determined by factors beyond my control:	0	1	2	3	4	5	6
c. Over the next 5±10 years I expect to have many more positive than negative experiences:	0	1	2	3	4	5	6
d. I often have the feeling that I am being treated unfairly:	0	1	2	3	4	5	6
e. In the past 10 years my life has been full of changes without my knowing what will happen next:	0	1	2	3	4	5	6
f. I gave up trying to make big improvements or changes in my life a long time ago:	0	1	2	3	4	5	6
g. Keeping healthy depends on things that I can do:	0	1	2	3	4	5	6
h. There are certain things I can do for myself to reduce the risk of a heart attack:	0	1	2	3	4	5	6
i. There are certain things I can do for myself to reduce the risk of getting cancer:	0	1	2	3	4	5	6

6. Have you felt sad, depressed or "blue" for two weeks or more in a row over the past 12 months?   Yes   No

   If Yes, have you:

   a. Lost interest in things?   Yes   No
   b. Felt tired or low on energy?   Yes   No
   c. Gained or lost weight?   Yes   No
   d. Had trouble falling asleep?   Yes   No
   e. Had trouble concentrating?   Yes   No
   f. Thought of death?   Yes   No
   g. Felt worthless?   Yes   No

7. Please rate how often you have been bothered by any of the following problems over the last 2 weeks using the following scale:

0=Not at All   1=Several Days   2=More than half the days   3=Nearly every day   DK=Don't know

a. Little interest or pleasure in doing things.	0	1	2	3	DK
b. Feeling down, depressed, or hopeless.	0	1	2	3	DK
c. Trouble falling or staying asleep OR sleeping too much.	0	1	2	3	DK
d. Feeling tired or having little energy.	0	1	2	3	DK
e. Poor appetite OR overeating	0	1	2	3	DK
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3	DK
g. Trouble concentrating on things, such as reading a newspaper or watching television.	0	1	2	3	DK
h. Moving or speaking so slowly that other people could have noticed OR—the opposite—being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3	DK

Please share your current self-care:

The next questions ask about how you have taken care of yourself over the **past 7 days.** If you were sick during the past 7 days, please think back to the last 7 days that you were not sick. **Mark the number of days you engaged in the activity** asked about in the question:

1. How many of the last SEVEN DAYS have you followed a healthful eating plan?	0	1	2	3	4	5	6	7	N/A
2. On average, over the past month, how many DAYS PER WEEK have you followed your eating plan?	0	1	2	3	4	5	6	7	N/A
3. On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables?	0	1	2	3	4	5	6	7	N/A
4. On how many of the last SEVEN DAYS did you eat high fat foods such as red meat or full-fat dairy products?	0	1	2	3	4	5	6	7	N/A
5. On how many of the last SEVEN DAYS did you limit starchy foods, or carbohydrates?	0	1	2	3	4	5	6	7	N/A
6. On how many of the last SEVEN DAYS did you eat whole grains?	0	1	2	3	4	5	6	7	N/A
7. On how many of the last SEVEN DAYS did you eat whole legumes?	0	1	2	3	4	5	6	7	N/A
8. On how many of the last SEVEN DAYS did you make food selections based on the type of fat they contain?	0	1	2	3	4	5	6	7	N/A
9. On how many of the last SEVEN DAYS did you participate in at least 30 minutes of physical activity? (total minutes of continuous activity, including walking).	0	1	2	3	4	5	6	7	N/A
10. On how many of the last SEVEN DAYS did you participate in a specific exercise session (such as swimming, walking, biking) other than what you do around the house or as part of your work?	0	1	2	3	4	5	6	7	N/A
11. On how many of the last SEVEN DAYS did you take your recommended medication(s)?	0	1	2	3	4	5	6	7	N/A
12. On how many of the last SEVEN DAYS did you take your recommended dietary supplements?	0	1	2	3	4	5	6	7	N/A
13. On how many of the last SEVEN DAYS did you participate in stress reduction activities such as meditation, journaling, spending time in nature, yoga, prayer, tai chi, or Qi gong?	0	1	2	3	4	5	6	7	N/A

Please share some of your challenges in self-care:

The following questions ask about your confidence in sticking to your eating and exercise plans in different situations. Using the following scale, share with us how confident you are in performing the activities asked about in the question:

0= Not at All Confident **4 = Somewhat Confident** **8 = Extremely Confident**

How confident are you that you would be able to									
1. Follow your eating plan when you are in a bad mood (e.g., anxious, depressed, irritable)?	0	1	2	3	4	5	6	7	8
2. Follow your eating plan when you are bored?	0	1	2	3	4	5	6	7	8
3. Follow your eating plan on the weekends?	0	1	2	3	4	5	6	7	8
4. Follow your eating plan when you are at a party or out to dinner with friends or family?	0	1	2	3	4	5	6	7	8
5. Follow your eating plan when many appealing high-calorie foods are available?	0	1	2	3	4	5	6	7	8
6. Follow your exercise plan when you get very busy?	0	1	2	3	4	5	6	7	8
7. Follow your exercise plan when it interferes with spending time with your friends or family?	0	1	2	3	4	5	6	7	8
8. Follow your exercise plan when you are sore or tired?	0	1	2	3	4	5	6	7	8
9. Follow your exercise plan when you are in a bad mood (e.g., anxious, depressed, irritable)?	0	1	2	3	4	5	6	7	8
10. Follow your exercise plan when your exercise workout is not enjoyable?	0	1	2	3	4	5	6	7	8
11. Follow your stress reduction plan when you are very busy?	0	1	2	3	4	5	6	7	8
12. Follow your stress reduction plan when it interferes with spending time with family or friends?	0	1	2	3	4	5	6	7	8
13. Follow your stress reduction plan when you are in a bad mood?	0	1	2	3	4	5	6	7	8
14. Follow your stress reduction plan when your stress reduction plan is boring?	0	1	2	3	4	5	6	7	8
15. Follow your stress reduction plan when your stress reduction plan does not seem to be working?	0	1	2	3	4	5	6	7	8

Please complete this page only if you are here to discuss diabetes care:

1. Which topics do you feel that you need to learn more about so you can take better care of yourself? (Mark all that interest you.)

- ☐ How to set goals for my health
- ☐ Healthy eating and reading food labels
- ☐ Physical activity: staying safe and comfortable
- ☐ What is diabetes, i.e., education about the disease process?
- ☐ Stress, my emotions, and their impact on my blood sugar
- ☐ Prescription medicines: what they are for and how to take them
- ☐ Home blood sugar monitoring: how to use the results
- ☐ My ABCs, or current values for blood sugar (A1c), blood pressure (B), and cholesterol (C)
- ☐ Balancing my blood sugar: lows, highs, and sick days
- ☐ Taking care of my feet
- ☐ Help with smoking cessation
- ☐ Planning for pregnancy
- ☐ Advice for my pain or other complications
- ☐ Other:

Please share more about how you learn best:

2. Do any of the following make it hard for you to learn about diabetes or make it more difficult to control your diabetes? (Check all that are true for you.)

- ☐ Trouble hearing
- ☐ Transportation
- ☐ Family/work schedule
- ☐ Trouble seeing
- ☐ Forgetfulness
- ☐ Paying for healthy food
- ☐ Trouble reading
- ☐ Trouble writing
- Other ______________________

____

3. Have you ever met with a health educator or nutritionist about your diabetes?

No   Yes   If Yes, how long has it been: ______________

4. Do you have any known complications, e.g., nerve pain, kidney problems, eye/vision problems due to your diabetes?

No   Yes   If Yes, please describe: ______________________________

Please tell us more about your history with blood sugar testing:

5. On how many of the last SEVEN DAYS did you test your blood sugar?   0 1 2 3 4 5 6 7

6. On how many of the last SEVEN DAYS did you test your blood sugar the number of times recommended by your heath care provider?   0 1 2 3 4 5 6 7

Please tell us about your history with medications:

7. Which of the following medications have you been on in the past? (Mark all that apply).

- Metformin (AKA Glucophage)
- Acarbose
- Avandia or Actos
- Byetta or Januvia
- Glipizide or Glyburide
- Insulin
- Other ______________________

____

____

8. Do you have any of the following concerns with your diabetes medications? (Mark all that apply.)

- Costs too much
- Run out often
- Do not think I need it
- Take differently than prescribed
- Problems with side effects. Explain:_____ ______________________
- Forget to take
- Other______________________ ______________________

9. Do you ever take extra medication?   No   Yes   If Yes, please describe: ______________________

10. Are you having problems with your diabetes medications now?   No   Yes   If Yes, please describe: ______________________

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