

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:

- | | |
|--|--|
| <input type="checkbox"/> Prevention of diabetes and/or heart disease | <input type="checkbox"/> Recent stroke |
| <input type="checkbox"/> Type 2 diabetes | <input type="checkbox"/> Recent surgery, i.e., bypass, angioplasty, etc. |
| <input type="checkbox"/> Type 1 diabetes | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations/arrhythmia |
| <input type="checkbox"/> High blood cholesterol | <input type="checkbox"/> Erectile dysfunction (men) |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Recent heart attack | |

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

- | | |
|--|--|
| <input type="checkbox"/> Improve my health | <input type="checkbox"/> Receive advice on stress management |
| <input type="checkbox"/> Reduce my symptoms | <input type="checkbox"/> Receive advice on dietary supplements/natural products |
| <input type="checkbox"/> Assess my risk for diabetes and/or heart disease | <input type="checkbox"/> Receive advice on other complementary medicine approaches to my condition |
| <input type="checkbox"/> Develop a long-term plan or program for my health condition | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Receive advice on diet | _____ |
| <input type="checkbox"/> Receive advice on exercise | _____ |

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

- | | |
|---|---|
| <input type="checkbox"/> One time advice for my health condition | <input type="checkbox"/> Adjunctive care for my health condition |
| <input type="checkbox"/> On-going management of my health condition | <input type="checkbox"/> I don't really know. I am interested in guidance, information or clarification about what I'm currently doing now for my health condition. |
| <input type="checkbox"/> Primary management of my health condition | |

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

- | | | | |
|--|---|---------------------------------------|---|
| <input type="checkbox"/> Reading | <input type="checkbox"/> Doing things | <input type="checkbox"/> Listening | <input type="checkbox"/> One on one |
| <input type="checkbox"/> Slides/Videos | <input type="checkbox"/> Have someone show me | <input type="checkbox"/> With a group | <input type="checkbox"/> Talking/Asking questions |

Please share some of your heart health history:

- | | | |
|---|-----|----|
| 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 than 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 |



Please share some information about your quality of life:

1. In general, would you say your health is? Circle: 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? Circle:
- Yes, a lot limited Yes, a little limited No, not limited at all
- 2b. Climbing **several** flights of stairs? Circle:
- 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** than you would like? Circle:
- 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? Circle:
- 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** than you would like? Circle:
- 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? Circle:
- 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)? Circle:
- 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? Circle:
- 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? Circle:
- 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? Circle:
- 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.)? Circle:
- All of the time Most of the time Some of the time A little of the time None of the time

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 circle 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

- | | | | | | | | |
|--|---|---|---|---|---|---|---|
| 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 | e. Had trouble concentrating? | Yes | No |
| b. Felt tired or low on energy? | Yes | No | f. Thought of death? | Yes | No |
| c. Gained or lost weight? | Yes | No | g. Felt worthless? | Yes | No |
| d. Had trouble falling asleep? | 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. **Circle 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
- Prescription medicines: what they are for and how to take them
- Taking care of my feet
- Healthy eating and reading food labels
- Home blood sugar monitoring: how to use the results
- Help with smoking cessation
- Physical activity: staying safe and comfortable
- My ABCs, or current values for blood sugar (A1c), blood pressure (B), and cholesterol (C)
- Planning for pregnancy
- What is diabetes, i.e., education about the disease process?
- Balancing my blood sugar: lows, highs, and sick days
- Advice for my pain or other complications
- Stress, my emotions, and their impact on my blood sugar
- 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
- Trouble seeing
- Trouble reading
- Transportation
- Forgetfulness
- Trouble writing
- Family/work schedule
- Paying for healthy food
- 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 health 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? (Circle all that apply.)

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

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

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

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: _____