AM NUTRITION SERVICES

"Providing Tools and Enhancing Skills To Improve Your Nutritional Health"

AM Nutrition Services' DSMES Program Self-Assessment
(to fill out prior to program start-date)

Our Dietitians thank you for filling out this information; plan on approximately 5-10 minutes to fill out these questions. We appreciate your time!

ABOUT YOU:

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____

Race:

☐ American Indian or Alaska Native ☐ Asian or Asian American ☐ Black or African American
☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Other: _____

Ethnicity:

☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Other: _____

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?
☐ YES ☐ NO
If YES, please describe: _____

What is your primary language? ☐ English ☐ Spanish ☐ Other: _____

Who do you live with? _____

How confident are you in filling out medical forms by yourself? ☐ Extremely ☐ Somewhat ☐ Not at All

REDUCING RISK:

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other: _____

When were you diagnosed with diabetes? _____

Have you had diabetes self-management education (DSMES) before? ☐ YES ☐ NO ☐ UNSURE

How often do you have high blood sugar?
☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

How often do you have low blood sugar?
☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

Do you Smoke? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO
In the past 12 months have you been to the emergency room because of diabetes? ☐ YES ☐ NO

In the past 12 months have you been admitted to the hospital because of diabetes? ☐ YES ☐ NO

Health History:

Other health conditions: _____

Do physical limitations interfere with your ability to manage your diabetes, get physical activity, or enjoy things that you like to do? ☐ YES ☐ NO

If YES, ☐ Hearing ☐ Vision ☐ Dexterity or use of hands ☐ Feet ☐ Pain ☐ Other: _____

Which of the following have you had or done in the past year?

☐ Dilated eye exam ☐ Dental exam ☐ Had Feet Checked ☐ A1C

☐ Cholesterol ☐ Blood pressure check ☐ Stopped smoking

HEALTHY COPING:

Who supports you in coping with the daily demands of managing diabetes?

☐ Family ☐ Friends/Coworkers ☐ Support Group ☐ Diabetes Care & Education Specialist

☐ Health Care Professional ☐ Other: _____

Respond to the following by answering often true, sometimes true, or never true:

Diabetes gets in the way of the rest of my life:

☐ Often True ☐ Sometimes True ☐ Never True

Feeling overwhelmed by taking care of my diabetes:

☐ Often True ☐ Sometimes True ☐ Never True

Feeling that I am often failing with my diabetes care:

☐ Often True ☐ Sometimes True ☐ Never True

BEING ACTIVE:

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). _____

How often do 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?

☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

HEALTHY EATING:

Do you follow a specific eating plan? ☐ YES ☐ NO

If yes, on how many of the last SEVEN DAYS did you follow your eating plan? _____

On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables? _____

On how many of the last SEVEN DAYS did you eat red meat or full-fat dairy foods? _____

TAKING MEDICATION:

Do you take diabetes medication? ☐ YES ☐ NO

If yes, check all that apply: ☐ pills ☐ injections ☐ insulin ☐ supplements

On how many of the last SEVEN DAYS, did you take your medication and/or injections? _____

On how many of the last 7 days did you miss taking one or more of your medications or injections? ____

MONITORING:

Do you check your blood sugar with a glucose meter or continuous glucose monitor (CGM)?

☐ YES ☐ NO

If YES, how often do you usually check your blood sugar? _____

Have you kept a food or activity log before? ☐ YES ☐ NO

PROBLEM SOLVING:

Please rate your agreement with the following statements:

I know what to do when my blood sugar goes higher or lower than it should be.

☐ YES ☐ NO ☐ UNSURE

I know when changes in my diabetes mean I should visit the doctor.

☐ YES ☐ NO ☐ UNSURE

I know I can manage my diabetes so that it does not interfere with the things I want to do.

☐ YES ☐ NO ☐ UNSURE

SOCIAL DETERMINANTS OF HEALTH:

Respond to the following by answering often true, sometimes true, or never true.

Within the past 12 months, I worried whether our food would run out before we had money to buy more. ☐ Often True ☐ Sometimes True ☐ Never True

Within the past 12 months, the food we bought just did not last and we didn't have money to get more.

☐ Often True ☐ Sometimes True ☐ Never True

How often does this describe you?

I don't have enough money to pay my bills:

☐ Often True ☐ Sometimes True ☐ Never True

I put off or neglect to go to the doctor because of distance or lack of transportation.

☐ Often True ☐ Sometimes True ☐ Never True

I am worried or concerned that I may not have stable housing soon.

☐ Often True ☐ Sometimes True ☐ Never True

I have a job.

☐ YES ☐ NO

DSMES PLAN:

Please check all areas that you are most interested in learning about:

☐ What is Diabetes ☐ Healthy Coping ☐ Healthy Eating ☐ Being Active

☐ Taking Medications ☐ Reducing Risk ☐ Monitoring ☐ Problem Solving

☐ Other: _____

List goals, questions, or concerns for your DSMES Team:_____

_____

_____

STAFF USE ONLY FROM THIS POINT FORWARD

Educator's Signature = Review of Assessment and Individualization of Patient's Education Plan	Initial Date	F/Up Date	F/Up Date
Please use RED INK for follow-up info.			

Test	Standardized Targets	Individual Targets	Date:	Date:	Date:	Date:	Date:	Date:
FPG-pre-prandial	80 – 130 mg**							
2 hr PP	≤ 180 mg**							
A1C	≤ 7%**							
Total Chol	< 200 mg**							
LDL-C	< 100 mg**							
HDL-C	> 35 mg**							
Triglycerides	< 150 mg**							
BP	< 130/80**							
U. Ketones	Negative**							
BMI	< 25***							
BMI Asian	< 23***							
Weight			☐ shoes	☐ shoes	☐ shoes	☐ shoes	☐ shoes	☐ shoes
Waist circum	< 35" F *** < 40" M ***							
Waist-hip ratio	< 0.80 F < 0.95 M ***							

Notes:

* Stage of Readiness to Change: PC = Pre-Contemplation; C = Contemplation; P = Preparation; A = Action; M = Maintenance; R = Relapse

** American Diabetes Association Standards of Medical Care in Diabetes, 2023

*** Online Nutrition Care Manual of Academy of Nutrition and Dietetics; accessed 4-2-23

Instructor signature validating review of initial assessment:
Instructor signature validating review of follow-up assessment: