

Initial Assessment

Alamance Regional Medical Center PO Box 202 Burlington NC 27216

The LifeStyle Center

What other medical problems do you have, besides Diabetes? _____

Do you have Sleep Apnea? YES NO If yes, do you use a CPAP or BiPAP machine at night? YES NO

Are you checking your blood sugar at home? YES NO When do you check? _____

Name of monitor used: _____ Usual results: _____

Have you had any of the following symptoms in the last 2-3 weeks? (circle all that apply)

- Extreme thirst frequent urination unusually tired blurry vision dry skin
Numbness tingling, pain in feet or hands leg cramps recent weight loss no symptoms

Have you had any of the following symptoms in the last 2-3 weeks? (circle all that apply)

- Suddenly:** shaky nervous sweaty weak irritable or confused rapid heart beat
Vision problems numbness in mouth/tongue passing out no symptoms

In the past year, have you had any hospitalizations, ER, or urgent care visits due to Diabetes? YES NO

If so explain when and why: _____

What problems (if any) do you have due to Diabetes? _____

- ...in your kidneys? _____
...in your nerves (nerve damage)? _____
...with sexual function (impotence, loss of desire, vaginal dryness)? _____
...with infections (yeast infections, athlete's foot, etc.)? _____
...in your feet? _____

Do you now have any pain due to Diabetic neuropathy? YES NO
(Neuropathy is often felt as pain, numbness, or tingling in the feet or hands.)

If YES, where are you feeling the pain? _____

Choose a face that best describes the pain you feel:



0

No Hurt



2

Hurts a Little Bit



4

Hurts a Little More



6

Hurts Even More



8

Hurts a Whole Lot



10

Hurts Worst

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How long does your pain last? _____ How often do you feel this pain? _____

Does your doctor know about this pain? YES NO

OFFICE USE: MD informed/ Date: _____

How are you treating this pain? _____ Is the treatment Dr-prescribed? _____

Is this treatment relieving your pain? YES NO _____

What makes your pain worse? _____

How many ~~times a week~~ do you check your feet for problems? (circle one)

Everyday 6 5 4 3 2 1 don't check

Have you had any falls in the last 12 months? YES NO If yes, when did you fall? _____

Do you have an assistive device for walking (cane, walker, wheelchair, scooter)? _____

When was your last visit with an eye doctor (month & year)? _____

When was your last visit with a dentist (month & year)? _____

How do you feel your health is overall? Excellent Good Fair Poor

How does having Diabetes make you feel (emotionally)? _____

Do you feel ready to make some lifestyle changes to control your blood sugar? (circle one)

YES NO MAYBE NOT YET BUT SOON I DON'T KNOW

Have you had any Diabetes education before? YES NO If yes, when and where? _____

How do you learn best? (Check all that apply)

() Reading/ visual () talking/discussion () listening () activity/hands-on () other : _____

What goals do you have for improving your health? (Check all that apply)

() improve blood sugars () decrease medications () prevent diabetes complications () lose weight

() lead a healthier lifestyle () quit smoking () become more fit () other : _____



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FOR OFFICE USE ONLY:

ABUSE/NEGLECT: Are there any issue of abuse or neglect that you need to share with us? Y N
 If yes, explain: _____ referral made: Y N

RISK FOR FALLS: Y N
 Alteration in orientation, altered mobility, fall in the last 12 months or additional indicators (i.e. medications, hypoglycemia, numbness/tingling in toes)

FALLS PREVENTION EDUCATION PROVIDED: Y N/A

NPSG #13 (INFECTION) HANDOUT PROVIDED: Y N/A

ADVANCE DIRECTIVES Literature offered

Living Will: Y N Health Care Power of Attorney: Y N
 Location: _____ Name of HCPOA: _____
 _____ Relationship: _____
 Location of HCPOA document: _____

MEDICARE QUESTIONS ASKED Y N/A

Completed/reviewed by (staff): _____

Date: _____

Time: _____ am/pm



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