MNT INITIAL ASSESSMENT FORM - DIAWEB

PATIENT INFORMATION

Name:	Age:
Sex: ☐ Male ☐ Female	Date of Birth:
Height:	Weight:
Home Phone:	Alternate phone:
Email Address:	

Race: ☐ White ☐ White/Hispanic ☐ Non-white Hispanic ☐ Black/Hispanic ☐ Black/African American
☐ American Indian/Alaskan Native ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian ☐ Guamanian or Chamorro
☐ Samoan ☐ Other Pacific Islander ☐ Biracial/Multiracial ☐ Other, Unknown, Unspecified

Primary Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Chinese ☐ French ☐ Other:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Last grade of school completed: ☐ Less than High School ☐ High School/GED ☐ Trade/Vocational
☐ Some College ☐ College Degree ☐ Advanced Degree

Occupation: ☐ Manual labor ☐ Professional ☐ Self-Employed ☐ Homemaker ☐ Retired
☐ Unemployed ☐ Student ☐ Trade/Vocational ☐ Disabled ☐ Unknown ☐ Other:

Hours worked per week: ☐ < 20 ☐ 20-40 ☐ > 40 ☐ N/A

Shift: ☐ Day ☐ Evening ☐ Night ☐ Rotating

Primary support person: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Child ☐ Parent(s) ☐ Other:

Primary caretaker: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Child ☐ Parent(s) ☐ Assisted Living
☐ Other:

Living Arrangements: ☐ Self ☐ Spouse ☐ Family ☐ Friend ☐ Child ☐ Parent(s)
☐ Assisted Living ☐ Group Home ☐ Other:

Learning Preference: ☐ Computer ☐ Reading ☐ Lecture ☐ Audio ☐ Hands on Demonstration
☐ Video ☐ Group Discussion ☐ No Preference

MEDICAL HISTORY

Have you met with a dietitian (nutritionist) in the past? ☐ No ☐ Yes
If yes, ☐ < 1 month ago ☐ 1-3 months ago ☐ 4-6 months ago ☐ 7-12 months ago
☐ 1-2 years ago ☐ 3-5 years ago ☐ 6-10 years ago ☐ > 10 years ago ☐ Unknown

If so, what was the reason for the visit with the dietitian?

What would you like to learn from today's visit?

Do you have any of the following?	☐ Eye Disease	☐ Kidney Disease	☐ Teeth/Gum problems
☐ Numbness/tingling	☐ Heart Problems	☐ High Blood Pressure	☐ High Cholesterol
☐ Asthma/Bronchitis/COPD	☐ Liver Disease	☐ HIV/AIDS	☐ Cancer
☐ Stomach Problems	☐ Thyroid Disorder	☐ Acid Reflux/GERD	☐ Anxiety/Depression
☐ Arthritis	☐ Sexual Problems	☐ Sleep Apnea	☐ Other:

Female Specific:
Are you pre-menopausal, post-menopausal, or currently pregnant? ☐ Pre-menopausal ☐ Post-menopausal
☐ None ☐ Currently pregnant and my due date is:

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MEDICATIONS

Medication Name	How much?	How often?	When?

Do you have any allergies to medications? ☐ No ☐ Yes, If yes, list allergies:

Do you ever forget to take medications? ☐ No ☐ Yes, If yes, why?

How many times per week do you miss a medication? ☐ Never ☐ <1 x per week ☐ 1 x per week ☐ 2-3x per week ☐ 4-6x per week ☐ 7 or more x per week

MEDICAL MANAGEMENT

In the past year, which of the below have you done? ☐ Complete physical exam ☐ Foot exam ☐ Dental exam ☐ Dilated eye exam ☐ Stress test ☐ Flu vaccination ☐ Pneumonia vaccination ☐ Hepatitis B vaccination ☐ Routine 3 month diabetes visit

In the last 3 months, have you been a patient in an emergency room? ☐ No ☐ Yes

If yes, what was the reason?

In the last 3 months, have you been admitted to a hospital? ☐ No ☐ Yes

If yes, what was the reason?

Has your weight changed over the past year? ☐ No ☐ Yes If yes, please explain:

Have you ever tried to change your weight? ☐ No ☐ Yes If yes, please explain:

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SELF-CARE BEHAVIOR

Do you drink alcohol? ☐ No ☐ Yes If yes, how often? ☐ Less than one drink per day
☐ 1-2 drinks per day ☐ 3 or more drinks per day ☐ Social occasions

Do you use recreational drugs? ☐ Yes ☐ No

Do you participate in regular physical activity/exercise? ☐ Yes ☐ No

Do you exercise for more than 150 minutes per week? ☐ Yes ☐ No

What type of exercise do you do? ☐ Aerobics ☐ Biking ☐ Cardiac rehab ☐ Combination ☐ Running
☐ Sports/athletics ☐ Stretching ☐ Swimming ☐ Walking ☐ Weights ☐ Other

How often do you exercise? ☐ <1 per week ☐ 1-2 x per week ☐ 3-4 x per week ☐ 5-6x per week
☐ 7 or more x per week)

How long do each of your exercise sessions last? ☐ < 15 minutes ☐ 15-30 minutes ☐ 31-45 minutes
☐ 46-60 minutes ☐ > 60 minutes

How would you rate the activity? ☐ Easy ☐ Moderate ☐ Difficult ☐ Strenuous

Do you have any physical limitations that prevent you from exercising? ☐ No ☐ Yes If yes, list:

How would you rate your overall health? ☐ Good ☐ Fair ☐ Poor

How important is your health to you? ☐ Extremely ☐ Somewhat ☐ Only when ill ☐ Not important

How would you rate your stress level? ☐ High ☐ Medium ☐ Low

Do you have a history of tobacco use? ☐ No ☐ Yes If yes, approximate quit date:

Do you currently smoke? ☐ Yes ☐ No
How much? ☐ Occasionally ☐ <5 per day ☐ ½ pack per day ☐ ¾ pack per day ☐ 1 pack per day
☐ >1 pack per day

MEAL PLAN

Do you follow a specific meal plan? ☐ No ☐ Yes If yes,
1. What kind?
2. How well do you follow your meal plan? ☐ 100% ☐ 75% ☐ 50% ☐ 25% ☐ <25%

Do you skip meals? ☐ Yes ☐ No

Who is responsible for preparing your meals? ☐ Self ☐ Spouse ☐ Both self & spouse ☐ Family
☐ Significant other ☐ Child ☐ Friend ☐ Parent ☐ In-home support ☐ Neighbor ☐ Other:_____

Who is responsible for buying your food? ☐ Self ☐ Spouse ☐ Both self & spouse ☐ Family
☐ Significant other ☐ Child ☐ Friend ☐ Parent ☐ In-home support ☐ Neighbor ☐ Other:_____

How often do you eat out? ☐ Daily ☐ 4-6x per week ☐ 1-3x per week ☐ Every other week
☐ Occasionally ☐ Never

Are you allergic or unable to tolerate certain foods? ☐ No ☐ Yes If yes, please explain:

Do you have any cultural or religious dietary practices? ☐ No ☐ Yes If yes, please explain:

Breakfast (Time: _____:_____)

Morning Snack: (Time: _____:_____)

Lunch (Time: _____:_____)

Afternoon Snack: (Time: _____:_____)

Dinner (Time: _____:_____)

Bedtime Snack: (Time: _____:_____)

Fluids:

Patient Signature: _____ Date: _____ Time: _____

Diabetes Educator Signature: _____ Date: _____ Time: _____

Educator Notes: _____

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