Ponca Tribe Diabetes Education Recognition Program
Educational Needs Assessment

Today's Date:_____

Name:_____ **Date of Birth:**_____

Height:_____ **Weight:**_____

List all the medications and vitamins you are currently taking:

Name:_____Dose:_____ Name:_____Dose:_____
Name:_____Dose:_____ Name:_____Dose:_____
Name:_____Dose:_____ Name:_____Dose:_____

Do you have any of the following? *(Check all that apply)*

□ High blood pressure □ Heart Problems □ Kidney Problems □ Eye Problems
□ Numbness/pain, burning in feet or hands □ Sore feet □ Slow healing
□ Impotence □ Frequent infections (urinary/vaginal) □ Feeling of fullness after eating; bloating

Family Members with Diabetes: □ Parents □ Brother/Sister □ Grandparents □ Grandchildren
(*Check all that apply)* □ Spouse □ Children □ Aunts/Uncles

Do you have any special cultural or religious dietary needs?_____
or observances?_____

Do you follow a special diet? □ Yes □ No If yes, explain:_____

Do you feel you have enough money to buy an adequate amount of food for your household?
□ Yes □ No

Have you ever met with a dietitian? □ Yes □ No

Do you smoke/use tobacco? □ Yes □ No
If yes, how many a day?_____ Type?_____

Do you use alcohol? □ Yes □ No
If yes, how much?_____ Type?_____ How often?_____

Do you work? □ Yes □ No

Do you get any exercise other than the usual days routine? □ Yes □ No
If yes, what kind?_____ How often?_____
How many minutes/week?_____

Is your physical activity limited? □ Yes □ No
If yes, explain_____

Do you have any of the following problems: (*Check all that apply)*

□ Vision Problems □ Hearing Problems □ Mobility Problems □ Loss of Sensation
□ Speak other Language besides English □ Difficulty Reading
□ Other _____

What education tools help you learn? ***(****Check all that apply)*

□ Reading □ Listening □ Doing things (*hands on)* □ Learning with a group
□ Slides or videos □ One on One □ Talking asking questions □ Have someone show you

What stage of change would you say you are in? *(Check one)*

□ Pre-contemplation: not considering making changes □ Contemplation: uncertain about making changes
□ Preparation: are currently trying to make changes □ Action: have been making changes for 3-6 months
□ Maintenance: have made commitment to sustaining new behavior for past 6 months to 5 years

Do you have diabetes? □ Yes □ No **If you checked no, you can <u>skip the following section</u> and sign at the bottom.**

When did you get diabetes?_____

Circle any of the following which describe your feelings about learning how to take care of your diabetes?

Angry Frightened Optimistic Not Necessary

Not Concerned Overwhelmed Puzzled

How would you rate your willingness to learn new ways to taking better care of yourself and your diabetes on a scale of 1 to 10?_____ ***(****1 being not willing, 10 being very willing)*

Do you check your blood sugar at home? □ Yes □ No If yes, how often?_____

What are your normal blood sugar results? (*Circle One)* 70-120 121-160 161-200 200-Over

Have you ever had a low blood sugar? □ Yes □ No If yes, how did it make you feel?_____
_____

Have you ever been hospitalized because of your diabetes? □ Yes □ No

Check the topics you would like to learn more about in regards to your diabetes:

□ What is diabetes
□ Coping with diabetes
□ Monitoring blood sugars
□ Exercise
□ Complications
□ Nutrition
□ Diabetes Medications
□ Lab Tests (*Cholesterol, A1C,)*
□ Footcare
□ Diabetes and Pregnancy

Other Comments:_____

_____

Patient Signature:_____