Last Revised 04/01/24

Illinois Pathways to Health by AgeOptions

Take Charge of Your Diabetes Plus Participant Assessment & Pre-Survey

Participant Number or Name: ____

Workshop ID: ___________ **Site Name:** ____

Start date of program: ______ / ______ / ______ (e.g., 05/01/24)

ABOUT YOU

1. How did you hear about this class?
   - ☐ Physician or member of my healthcare team
   - ☐ Insurance Company
   - ☐ Community Organization
   - ☐ Care Coordinator
   - ☐ Family member/friend
   - ☐ Flyer
   - ☐ Facebook
   - ☐ Instagram
   - ☐ Twitter
   - ☐ Other social media
   - ☐ Health fair/ community event
   - ☐ Congregate/ home delivered meal notification
   - ☐ Information Session/ presentation
   - ☐ Email
   - ☐ Newsletter/ mass communication
   - ☐ Print ad/ newspaper
   - ☐ Radio/ pod cast
   - ☐ Religious Institution
   - ☐ Other: ________________________________

2. Did your doctor or other health care provider suggest that you attend this program?
   ☐ Yes ☐ No

3. How old are you today? _______ years

4. Do you live alone? ☐ Yes ☐ No

5. Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

6. What is your race? **Check all that apply.**
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Some other race (please specify): ____________________________________

7. What is your current gender? **Select ONE**.
   - ☐ Man
   - ☐ Woman
   - ☐ Non-binary
   - ☐ ________________________________(please specify)
   - ☐ Prefer not to answer

8. Do you consider yourself to be transgender?
   ☐ Yes ☐ No ☐ Prefer not to answer

9. Which of the following best represents how you think of yourself? **Select ONE**.
   - ☐ Lesbian or gay
   - ☐ Straight, that is, not gay or lesbian
   - ☐ Bisexual
   - ☐ [If respondent is AIAN:] Two-Spirit
   - ☐ I use a different term (please specify) ____________
   - ☐ Don't know
   - ☐ Prefer not to answer

10. What is the highest grade or year of school you completed?

	Some elementary, middle, or high school			Some college or technical school
	High school graduate or GED			College (4 years or more)

11. Have you ever served in the military? ☐ Yes ☐ No

12. During the past year, did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability? ☐ Yes ☐ No

13. Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?
   - ☐ Yes- Please describe: ____
   - ☐ No

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

REDUCING RISK

15. What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other: ___________

16. When were you diagnosed with diabetes? ____

17. Have you had diabetes self-management education (DSMES) before? ☐ Yes ☐ No ☐ Unsure

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

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

20. Do you smoke? ☐ Yes ☐ No

21. Do you drink alcohol? ☐ Yes ☐ No

22. In the past 12 months have you been to the emergency room because of diabetes? ☐ Yes ☐ No

23. In the past 12 months have you been admitted to the hospital because of diabetes? ☐ Yes ☐ No

HEALTH HISTORY

24. In general, would you say that your health is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

25. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)? **Please use an X to indicate your response Yes or No.**

	YES	NO		YES	NO
Alzheimer's Disease or other Dementia			Kidney Disease		
Anxiety Disorder			Malnutrition		
Arthritis/Rheumatic Disease			Obesity		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Post-Traumatic Stress Disorder		
Chronic Pain			Schizophrenia or other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Substance Use Disorder		
Heart Disease			Urinary Incontinence		
High Cholesterol			Other Chronic Condition		
Hypertension (High Blood Pressure)					

26. Please use an **X** to indicate your response to the following questions.

	YES	NO
a. Are you deaf or do you have serious difficulty hearing?		
b. Are you blind or do you have serious difficulty seeing, even when wearing glasses?		
c. Do you have serious difficulty walking or climbing stairs?		
d. Do you have difficulty dressing or bathing?		
e. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?		
f. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?		

27. How often do you feel lonely?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

28. How often do you feel isolated from those around you?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

29. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure 1 2 3 4 5 6 7 8 9 10 Totally sure

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

	Dilated eye exam		Cholesterol
	Dental Exam		Blood Pressure Check
	Had Feet Checked		Stopped Smoking
	A1C		

HEALTHY COPING

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

	Family		Diabetes Care & Education Specialist
	Friends/ Coworkers		Health Care Professional
	Support Group		Other: ____________________________

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

	Often True	Sometimes True	Never True
a. Diabetes gets in the way of the rest of my life:	☐	☐	☐
b. Feeling overwhelmed by taking care of my diabetes:	☐	☐	☐
c. Feeling that I am often failing with my diabetes care:	☐	☐	☐

BEING ACTIVE

33. On how many of the last 7 DAYS did you participate in at least 30 minutes of physical activity? (Total minutes of continuous activity, including walking): _____________ days

34. 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 your work?
☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

HEALTHY EATING

35. Do you follow a specific eating plan?
☐ Yes- How many of the last 7 DAYS did you follow your eating plan? _______ days
☐ No

36. How many of the last 7 DAYS did you eat 5 or more servings of fruit and vegetables? _______ days

37. How many of the last 7 DAYS did you miss taking one or more of your medications or injections? ______ days

TAKING MEDICATION

38. Do you take diabetes medication?
☐ Yes- Check all that apply: ☐ Pills ☐ Injections ☐ Insulin ☐ Supplements
☐ No

39. How many of the last 7 DAYS did you take your medication and/or injections? _________ days

40. How many of the last 7 DAYS did you miss taking one or more of your medications or injections? ________ days

MONITORING

41. Do you check your blood sugar with a glucose meter or continuous glucose monitor (CGM)?
☐ Yes- How often do you usually check your blood sugar? _______________________
☐ No

42. Have you kept a food or activity log before? ☐ Yes ☐ No

PROBLEM SOLVING

43. Please rate your agreement with the following statements:

	Yes	No	Unsure
a. I know what to do when my blood sugar goes higher or lower than it should be:	☐	☐	☐
b. I know when changes in my diabetes mean I should visit the doctor:	☐	☐	☐
c. I know I can manage my diabetes so that it does not interfere with the things I want to do:	☐	☐	☐

SOCIAL DETERMINANTS OF HEALTH

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

Within the last 12 months:	Often True	Sometimes True	Never True
a. I worried whether our food would run out before we had money to buy more:	☐	☐	☐
b. The food we bought just did not last and we didn't have money to get more:	☐	☐	☐

45. How often does this describe you?

	Often True	Sometimes True	Never True
a. I don't have enough money to pay my bills:	☐	☐	☐
b. I put off or neglect to go to the doctor because of distance or lack of transportation:	☐	☐	☐
c. I am worried or concerned that I may not have stable housing soon:	☐	☐	☐

46. I have a job: ☐ Yes ☐ No

DSMES PLAN

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

	What is Diabetes		Reducing Risk (ex. make an action plan such as setting achievable weight loss goal, communicate better with my doctor)
	Healthy Coping (ex. increase support from family or friends, manage depression)		Monitoring (ex. increase blood sugar monitoring)
	Healthy Eating (ex. eat healthier/follow a meal plan)		Problem Solving (ex. treat complications such as foot pain, low vision & energy)
	Being Active (ex. increase exercise/physical activity)		Other: ___________________________
	Taking Medications (ex. give myself injections correctly)		

48. List goals, questions, or concerns for your DSMES Team:

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