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Community Health Centre
130 Wilson Avenue
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Phone: 705-264-2200
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Diabetes Education Program New Client Intake Form

Demographics

Name *(Last, First, M.I.)*____

Date of Birth: (DD,MM,YYYY) ____________________ **Sex**: ☐ Male ☐ Female ☐ Intersex

☐ Trans- Female to Male ☐ Trans- Male to Female ☐ Two-Spirit ☐ Other________________________

Address: _______________________________ City: _______________________ Postal **Code:** ___________

Telephone Number: _____________________________ **Alternate Number:** ________________________

Health Card Number: ____________________________ **Version Code:** ________ Expiry: _______________

Status Card Number: ____________________________ **Band Name:** ______________________________

Spoken Language: ___________________________ Religion: ______________________________________

Race/Ethnic Origin: (circle) First Nation Métis Other_____________________________________

Country of Origin: (circle) Canada Other ____

Living Arrangement: (circle all that apply)

Alone **Family:** Spouse Children Parents Siblings

Extended Family **Friends** **Foster Family** **Boarding Home**

IN CASE OF EMERGENCY:

Contact Name(s):____

Relationship: _____________________________ Phone Number: __________________________________

Have you ever been a client of Misiway? ____

Have you received services from a Diabetes Education Program in the past? ☐**Yes** ☐ **No**

If yes, what was the name of the Diabetes Education Program? ________________________________

Who is your primary health care provider? ____

Do you have? ☐**Type 2 Diabetes** ☐**Pre-Diabetes** ☐**At Risk of Diabetes**

Do you take meds for your diabetes? ☐**Pills** ☐ **Insulin** ☐**Diet only**

Have you been admitted to the hospital or gone to the emergency because of your diabetes in the past 3 mths? ☐**Yes** ☐**No**

Name of pharmacy: ____

Drug Plan: ODB ☐ **NIHB** ☐ **Other** ☐____

Your Medical History

Please indicate if **YOU** have a history of the following:

☐Alcohol Abuse

☐ Anxiety Disorder

☐ Bladder Problems

☐ Bleeding Disease

☐ Blood Clots

☐ Kidney Disease

☐ Leg or foot ulcers

☐ Bowel Disease

☐ Cancer: Type _______________

☐ Depression

☐Pain/Chronic Pain

☐ Neuropathy (diabetes affecting the nerves)

☐ Heart Disease

☐Thyroid Problems

☐ Stroke/CVA

☐ Eye problems related to diabetes

☐ Sleep apnea

List other past medical problems:

____

____

____

____

____

____

____

____

Please list the medications you take:

Medication	Length of Time	Dose	Frequency
For example: Ibuprofen	1 Week	400 mg	2 x day

☐ I take no medications, vitamins, herbals or any over the counter preparations.

☐ I give authorization for Misiway CHC to call my pharmacy to request an up to date list of my medications.

Taking medication is an important part of keeping diabetes under control. We want to know if you are having difficulty taking your medication as prescribed.

How many days per week to you take your medication as prescribed? (Circle one)

1 2 3 4 5 6 7

Allergies:

Name:________________________________Reaction you had: ___________________________________

☐ I have no known **drug** allergies.

Nutritional Supplements – Please use the chart below to list all vitamins, minerals, amino acids, or other supplemental products (meal replacement drinks, bars, etc.) you are currently taking.

Supplement	Brand	Form	Dose/Frequency	Length of Time
For example: *Vitamin E*	*Nature's Made*	*Soft Gel Cap*	*400IU 1 X day*	*6 months*

Tobacco

Do you use tobacco? ☐Y ☐N

☐ Cigarettes – pks./day_______or pks./week _______

☐ Chew - #/day_______☐ Pipe - #/day_______☐ Cigars - #/day_______

Number of years_______Previous tobacco user - year quit __________

Alcohol

If yes, what kind?________________________________ How many drinks per week?___________

Are you concerned about the amount you drink? ☐Y ☐N

Have you considered stopping?............................ ☐Y ☐N

Have you ever experienced blackouts?..................☐Y ☐N

Are you prone to "binge" drinking?**.......................☐Y ☐N**

Drugs

Do you currently use recreational or street drugs? ☐**Y** ☐**N** If yes, which drugs are you using?

____

Tell us about your eating habits:

Are you eating differently since you found out you have diabetes**:** **Yes** ☐ **No**☐ **Don't know**☐

If yes, what changes have you made? **____**

How many times per day do you eat: **one** ☐ **two** ☐ **three**☐ **Four or more**☐

Which meals do you tend to skip? **Breakfast**☐ **Lunch**☐ **Supper** ☐ **None**☐

Who does the cooking in your house**?** **Self**☐ **Spouse**☐ **Other**☐

Within the past three months, did you ever worry whether your food would run out before you got money to buy more? **Yes** ☐ **No** ☐

Within the past three months, was there ever a time when the food you bought just didn't last and you didn't have money to get more? Yes☐ No☐

Within the past three months, did you or others in your household cut the size of your meals or skip meals because there was not enough money for food? Yes☐ No☐

Do you exercise: Yes ☐ No☐

If no, what makes it hard for you to exercise? ____

If yes, how often do you exercise: ________minutes per day _________days per week?

Do you check your blood sugar? Yes ☐ No☐

If yes, what type of blood sugar device do you use? ____

How often: Once a day☐ 2 or more/day☐ 1 or more/week☐ Occasionally ☐

When: before breakfast ☐ 2 hours after meals☐ at Bedtime☐

Has your blood sugar been high lately? Yes☐ No ☐ Don't know☐

If yes, how high and for how long? ____

Have you had any low blood sugars lately? Yes ☐ No☐ Don't know ☐

If yes, do you know why it was low? ____

What did you use to treat your low blood sugar? ____

Check any of the following tests/procedures you have had in the last 12 months

Eye exam☐ Foot exam☐ Dental exam☐ Cholesterol test ☐ A1c☐ Flu shot ☐

Pneumonia shot☐

PLEASE BRING YOUR BLOOD SUGAR DEVICE TO YOUR APPOINTMENT.

PLEASE SIGN THE CONSENT TO RELEASE YOUR PERSONAL HEALTH INFORMATION.