DSMES ASSESSMENT TEMPLATE

This template is intended to guide the comprehensive DSMES assessment process. The questions herein may be used to guide a verbal assessment process, serve as a template for a self-assessment completed by the participant on paper or through a secure portal, or adapted to meet your specific target population's needs. Any information gathered here is intended to inform the learning needs of the participant and inform the education plan within DSMES. This form meets the minimum requirements for an accredited DSMES program, but programs are not required to use this form. Questions have been adapted from validated tools and resources and follow a standardized format.

ABOUT YOU:

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____

Race:

☐ American Indian or Alaska Native ☐ Asian or Asian American ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Other: _____

Ethnicity:

☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Other: _____

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?

☐ YES ☐ NO If YES, please describe: _____

What is your primary language? ☐ English ☐ Spanish ☐ Other: _____

Who do you live with? _____

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

REDUCING RISK

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other: _____

When were you diagnosed with diabetes?

Have you had diabetes self-management education (DSMES) before? ☐ YES ☐ NO ☐ UNSURE

How often do you have high blood sugar?

☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

How often do you have low blood sugar?

☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

Do you Smoke? ☐ YES ☐ NO Do you drink alcohol? ☐ YES ☐ NO

In the past 12 months have you been to the emergency room because of diabetes? ☐ YES ☐ NO

In the past 12 months have you been admitted to the hospital because of diabetes? ☐ YES ☐ NO

Health History:

Other health conditions: _____

Do physical limitations interfere with your ability to manage your diabetes, get physical activity, or enjoy things that you like to do? ☐ YES ☐ NO

If YES, ☐ Hearing ☐ Vision ☐ Dexterity or use of hands ☐ Feet ☐ Pain ☐ Other: _____

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

☐ Dilated eye exam ☐ Dental exam ☐ Had Feet Checked

☐ A1C ☐ Cholesterol ☐ Blood pressure check

☐ Stopped smoking

HEALTHY COPING

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

☐ Family ☐ Friends/Coworkers ☐ Support Group ☐ Diabetes Care & Education Specialist

☐ Health Care Professional ☐ Other: _____

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

Diabetes gets in the way of the rest of my life:

☐ Often True ☐ Sometimes True ☐ Never True

Feeling overwhelmed by taking care of my diabetes:

☐ Often True ☐ Sometimes True ☐ Never True

Feeling that I am often failing with my diabetes care:

☐ Often True ☐ Sometimes True ☐ Never True

BEING ACTIVE

On how many of the last SEVEN DAYS did you participate in at least 30 minutes of physical activity? (Total minutes of continuous activity, including walking). _____

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 of your work?

☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

HEALTHY EATING

Do you follow a specific eating plan? ☐ YES ☐ NO

If yes, on how many of the last SEVEN DAYS did you follow your eating plan? _____

On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables?_____

On how many of the last SEVEN DAYS did you eat red meat or full-fat dairy foods?_____

TAKING MEDICATION

Do you take diabetes medication? ☐ YES ☐ NO

If yes, check all that apply: ☐ pills ☐ injections ☐ insulin ☐ supplements

On how many of the last SEVEN DAYS, did you take your medication and/or injections? _____

On how many of the last 7 days did you miss taking one or more of your medications or injections? _____

MONITORING

Do you check your blood sugar with a glucose meter or continuous glucose monitor (CGM)?

☐ YES ☐ NO If YES, how often do you usually check your blood sugar? _____

Have you kept a food or activity log before? ☐ YES ☐ NO

PROBLEM SOLVING:

Please rate your agreement with the following statements:

I know what to do when my blood sugar goes higher or lower than it should be

☐ YES ☐ NO ☐ UNSURE

I know when changes in my diabetes mean I should visit the doctor

☐ YES ☐ NO ☐ UNSURE

I know I can manage my diabetes so that it does not interfere with the things I want to do.

☐ YES ☐ NO ☐ UNSURE

SOCIAL DETERMINANTS OF HEALTH:

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

Within the past 12 months, I worried whether our food would run out before we had money to buy more.

☐ Often True ☐ Sometimes True ☐ Never True

Within the past 12 months, the food we bought just did not last and we didn't have money to get more.

☐ Often True ☐ Sometimes True ☐ Never True

How often does this describe you?

I don't have enough money to pay my bills:

☐ Often True ☐ Sometimes True ☐ Never True

I put off or neglect to go to the doctor because of distance or lack of transportation.

☐ Often True ☐ Sometimes True ☐ Never True

I am worried or concerned that I may not have stable housing soon

☐ Often True ☐ Sometimes True ☐ Never True

I have a job. ☐ YES ☐ NO

DSMES PLAN:

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

☐ What is Diabetes ☐ Healthy Coping ☐ Healthy Eating ☐ Being Active

☐ Taking Medications ☐ Reducing Risk ☐ Monitoring ☐ Problem Solving

☐ Other: _____

List goals, questions, or concerns for your DSMES Team: _____

_____

_____