Medical Nutrition Therapy
Diabetes Education

a division of: PCP Primary Care Partners, P.C.

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INITIAL ASSESSMENT

Date _____
Name _____ Sex _____ Date of Birth _____
Address _____
City _____ State ____ Zip Code _____ Home Phone _____
Work Phone _____

Referring Primary Care Physician _____
Insurance Company _____
Height _____ Weight _____ Blood Pressure _____

Diabetes History _____
Type I _____ Type II _____ Had Diabetes Since _____
Diabetes Medications
Name _____ Dose _____ Time Taken _____
_____ _____ _____

Blood Glucose Testing _____ Times/Day _____
Type of Meter Used _____
Chronic Complications (If present, describe)
Eye Problems _____
Nerve Problems _____
Kidney Problems _____
Foot Problems _____
Heart Problems _____
Frequent Infections _____
Eating Habits _____
Current Diet _____ Usual Meal Times _____
Snacks _____ Usual Snack Times _____
Who Cooks? _____ How Often Do You Eat Out? _____
Biggest Challenges to Eating Healthy _____
Exercise Routine _____
Type of Exercise _____ How Often _____ For How Long _____

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CERTIFIED DIABETES EDUCATOR

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