UNITED MEDICAL
ACCOUNTABLE CARE ORGANIZATION

Diabetes Self-Management Education
Initial Intake

Name: _____ Date of Birth: _____
Physician or Clinic: _____ Phone Number: ( ) _____-_____
Medications: _____

Please complete the questions below to your best ability.

1. **Do you have any physical limitations?**
   Check the box for any of the following that are true.

   □ Wheelchair bound □ Difficulty standing
   □ Difficulty walking □ Limited sight
   □ Limited hearing □ None
   Other: *Please explain* _____

2. **Do you have any financial concerns regarding your healthcare?**

   □ No
   □ Yes: *Please explain* _____

3. **Are there any cultural influences that may affect your diabetes care?**

   (Example: fasting, certain food groups you can't eat)
   □ No □ Yes: *Please explain* _____

4. **Do you know of any risk factors related to your diabetes care?**

   Check the box for any of the following that are true:

   □ I have high cholesterol □ I have high blood pressure
   □ I have sleep apnea □ I have nerve issues because of my diabetes
   □ I have eye problems because of my diabetes
   □ None
   □ **Other:** *Please explain* _____

5. **How often do you check your blood sugar?**

   □ 1 time a day □ I don't check my sugar at home
   □ 2 times per day □ I don't have a meter
   □ 3 or more times per day

6. **I have used the following resources to help me learn about my diabetes:**

   □ State of Delaware diabetes program □ I met with a diabetes educator
   □ Diabetes.org □ Diabetes support group
   □ None
   □ **Other**: *Please explain* _____

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AADE American Association of Diabetes Educators

United Medical ACO has linked with the American Association of Diabetes Educators (AADE) to provide and support you with the most effective diabetes care available. We're in this together. The focus of care is on you! The AADE 7 Self-Care Behaviors™ are self-care behaviors essential for successful and effective diabetes self-management. *What self-care goals are you working on for improved diabetes management?*
Check all that apply and write in your own special goals.

1. *Healthy Eating*
   ___ Make better food choices ___ Reduce portion sizes ___ Follow meal plan
   ___ Count carbs ___ Read food labels ___ Keep a food log
   ___ Individual Goal:

2. *Being Active*
   ___ Increase exercise time ___ Exercise more frequently ___ Try a new type of activity
   ___ Increase exercise intensity ___Make a FITT Plan (Frequency, Intensity, Time, Type)
   ___ Individual Goal:

3. *Monitoring*
   ___ Follow monitoring schedule ___ Monitor glucose more often ___ Keep a glucose log
   ___ Monitor heart health (bp) ___ Monitor kidneys ___ See eye doctor
   ___ Lower A1c ___ Foot health ___ See dentist
   ___ Individual Goal:

4. *Taking Medication*
   ___ Taking medication on time ___ Miss fewer medications ___ Take med as prescribed
   ___ Individual Goal:

5. *Problem Solving*
   ___Identify potential problems ___ Plan problem treatment ___ Prevent problem
   ___ Individual Goal:

6. *Healthy Coping*
   ___ Cope with diagnosis of disease ___ Adapt to lifestyle changes ___ Seek support
   ___ Think positive ___Be good to yourself ___ Pursue hobbies
   ___ Individual Goal:

7. *Reducing Risk*
   ___ Stop smoking ___ Get health checkups ___ Individual Goal
   ___ Perform daily self-care activities

Patient Signature _____ Date _____

Provider Signature _____ Date: _____