Pediatric Assessment Date:
For Children 10 years of age or younger
(This assessment is intended for kids that need someone else to complete form)

Lifestyle/Physical Activity

Child's Name: _____ Age: _____ DOB: _____

Preferred method of communication: ☐Phone ☐Text ☐Email - Do you use: ☐Computer ☐Tablet ☐Smart phone

Primary Language: _____

List cultural or religious beliefs that may impact your care: _____

How does child learn best? ☐Written materials ☐Verbal Discussion ☐Video ☐_____

Does child have difficulty with? (Circle all that apply) Listening-Reading–Writing-Hearing-Seeing-Understanding

Person completing this form: _____Relationship to Child_____

Parent's Marital Status (if applicable): ☐Single ☐Married ☐Divorced ☐Widowed

Preferred method of communication: ☐Phone ☐Text ☐Email Do you use: ☐Computer ☐Tablet ☐Smart phone

How do you learn best? ☐Written materials ☐Verbal Discussion ☐Video ☐_____

Do you have difficulty with? (Circle all that apply) Listening-Reading–Writing-Hearing-Seeing-Understanding

*Do you need help understanding instructions, pamphlets, or other written material from doctor or pharmacy? ☐No – ☐Sometimes - ☐Always

Child's typical weekday schedule: Lives with (including siblings): _____

Sleep, School, (Work, Sports, Exercise type), schedule: _____

_____

Describe any diabetes concerns with any of the above activities: _____

_____

Child's typical weekend schedule: Lives with (including siblings): _____

Sleep, School, (Work Sports, Exercise type), schedule:_____

_____

Describe any diabetes concerns with the above activities: _____

_____

Does child use tobacco products? ☐No ☐Yes Type/Amount/Quit Date: _____

Does the child drink alcohol ☐No ☐Yes Type/Amount/Quit Date?

Diabetes Distress Support/Healthy Coping

Describe any stress with life the child is experiencing.

_____

Describe any financial stress the family is experiencing.

_____

In child's own words what is diabetes?

_____

_____

_____

Please state if the child would agree, is neutral, or disagree with the following statements:

- How would the child rate their overall health? ☐ Excellent ☐ Good ☐ Fair ☐Poor
- My diabetes interferes with other aspects of my life. ☐Agree ☐Neutral ☐Disagree
- My level of stress is high. ☐Agree ☐Neutral ☐Disagree
- I have some control over whether I get diabetes complications or not. ☐Agree ☐Neutral ☐Disagree
- I struggle with making changes in my life to care for my diabetes. ☐Agree ☐Neutral ☐Disagree

What concerns your child most about diabetes?

_____

What is hardest for child in caring for their diabetes?

_____

What are the child's thoughts or feelings about this issue ☐Frustrated ☐Angry ☐Guilty ☐Other? -

_____

Who does the child get support for diabetes from? ☐Parent/s ☐Grandparent/s ☐Siblings ☐Teacher ☐School Nurse ☐Employer ☐Coach ☐Pediatrician
☐Other_____

Who else in the child's family has diabetes and what type?

How does child handle stress?

_____

Circle If the child has or is receiving counseling from social worker, psychologist or psychiatrist and would you allow the office to speak with them? ☐No ☐Yes Name: _____ Phone: _____

Health History, Diabetes Type and Preventative Exams

The child was diagnosed with ☐Type 1 ☐Type 2 ☐Pre-diabetes at the age of _____ date _____.

List any surgeries or procedures planned in next 3 months: _____

Does the child have any of the following due to diabetes: ☐No

☐Eye Issues ☐Nerve Pain ☐Kidney Issues ☐High Blood Pressure ☐High Cholesterol

☐Heart disease ☐Thyroid Disease ☐Foot Issues ☐Frequent Infections ☐Dental Issues

☐Other: _____

Which tests/procedures has the child had in the last 12 months.

☐Dilated eye exam ☐Urine test for protein ☐Foot exam ☐self or ☐healthcare provider
☐Dental exam ☐Blood pressure ☐Cholesterol ☐A1C
☐Flu shot ☐Pneumonia shot ☐COVID 19 vaccine

Endocrinologist name: _____ last visit date: _____

Primary Care Providers name: _____ last visit date: _____

Other specialists the child sees:

Medications and Supplements

List any medication allergies and reaction: _____

_____

*List Diabetes Medications and how they are stored: _____

_____

*Insulin Injections: If child uses an insulin pump go to that section.

- Who gives the injections? _____
- What injection sites are used? _____
- Insulin types and vials or pens and how dose is determined: _____

_____

*Insulin Pump: Pump Name: _____

- How many years has the child been using an insulin pump? ☐Less than 1 ☐1-2 ☐3 or more
- Does it work with a CGM? ☐Yes ☐No ☐Not sure
- Does the child have an off-pump insulin injection plan? ☐No ☐Not Sure ☐Yes, it is: _____

  _____
- Does the child have a DKA prevention plan? ☐No ☐Not Sure ☐Yes, it is: _____

  _____
- List pump basal rates, carb ratios, correction factors and glucose target ranges below if you know them. ☐I do not know them ☐See attached pump settings report.

Time	Basal Rate	Carb Ratio	Correction Factor	Glucose Target
12:00 am	_____	_____	_____	_____

__: __ _m _____ _____ _____ _____

__: __ _m _____ _____ _____ _____

__: __ _m _____ _____ _____ _____

__: __ _m _____ _____ _____ _____

Use back of page if more space is needed.

How often in a week does the child miss their insulin dose? ☐Never ☐Once ☐1-2 ☐3 or more

Other Medications the child takes (prescription or over the counter) and why? _____

_____

Vitamins or supplements the child takes:

Monitoring Glucose (BGM) and Continuous Glucose Monitoring (CGM)

What type of glucose meter and CGM (if applicable) does the child use? _____

_____

How often does your child/you check their glucose level? ☐Never
☐1-2 times per day ☐3-4 times per day ☐5-6 times per day ☐More than 6 times per day

*What are your child's blood glucose targets?

_____ to _____before meals _____ to _____after meals _____ to _____before bed

_____ to _____before physical activity _____ to _____before school/daycare

What range are your child's blood glucose at the below times:

_____ to _____before breakfast _____ to _____before lunch _____ to _____before dinner

_____ to _____before bed _____ to _____before physical activity _____ to _____before school/daycare

*If using a CGM what is the child's target:

- Time in Range (TIR): _____ % ☐Do not know ☐Have not been taught this
- Glucose Management Index (GMI): _____ % ☐Do not know ☐Have not been taught this

If you re monitoring these please enter for the past 14 days CGM's: TIR = _____% GMI = _____%

Acute Complications and Sick Days

Does your child wear or carry a medical alert for diabetes? ☐No ☐Yes type: _____

In the past 6 months due to diabetes: _____days missed of school _____days missed of sports, other interests.

List any hospital/ER/Urgent Care visits in past year due to diabetes and why: _____

_____

In the past week, how often has the child had a low glucose? ☐Never ☐1time ☐2-3 times ☐4-6 times ☐daily ☐multiple times a day.

What low glucose symptoms does the child have and at what glucose level? _____.

Please describe any particular time of day or activity associated with the low glucose levels. _____

_____

How are the low glucose levels treated? _____

*Do you have and know how to use glucagon? ☐No ☐Yes Type of glucagon: _____

In the past year how many times has the child required glucagon? ☐None ☐Once ☐2-4 ☐5 or more

In the past week, how often has the child had a glucose of 300 or higher? ☐Never ☐1time ☐2-3 times ☐4-6 times ☐daily ☐multiple times a day.

What high glucose symptoms does the child have and at what glucose level? _____.

Please describe any time of day or activity associated with the high glucose levels. _____

_____

*What do you do when glucose levels are high? _____

*Do you have and know how to use ketone test strips? ☐No ☐Yes Type of ketone test: ☐Urine ☐Blood

*In the past year how many times has the child had ketones? ☐Do not know ☐None ☐Once ☐2-4 ☐5 or more

*Please describe why the child had ketones. _____

*What do you do when the child has ketones? _____

*How is the diabetes managed when the child is sick?

_____

Eating Patterns

List any food allergies and GI issues: _____

List food likes and dislikes: _____

Does the child follow any special eating pattern? ☐No ☐Low Sodium ☐Low Fat ☐Gluten Free

How many times does the child eat out each week? ☐Never ☐1-2 ☐3 -5 ☐6 or more

How many times per week does the child eat fast food? ☐Never ☐1-2 ☐3 -5 ☐6 or more

How many school/day care meals does the child eat daily? ☐Never ☐1 ☐2 ☐3

*Does the child: count carbs ☐Yes ☐No Read food labels ☐Yes ☐No Use carb counting apps ☐Yes ☐No

*Circle what you or the child do: Count Carbs - Read Food Labels - Use Carb Counting Apps

If carb counting apps are used which one/s: _____

Please list in a typical day the times and what the child eats and drinks.

	Time	Eats and Drinks
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Have you or the child received diabetes self-management education before? ☐Yes ☐No ☐Not sure

Have your or your child met with a dietitian concerning diabetes before? ☐Yes ☐No ☐Not sure

What would you like to learn about today?

**Indicates health literacy assessment item*

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