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| **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* | | |
| Created 5/2022 | | |