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

### Lifestyle/Physical Activity

<table>
<thead>
<tr>
<th>Child’s Name: ____________________________</th>
<th>Age: _______ DOB: ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred method of communication: □ Phone □ Text □ Email - Do you use: □ Computer □ Tablet □ Smart phone</td>
<td></td>
</tr>
<tr>
<td>Primary Language: ____________________________</td>
<td></td>
</tr>
<tr>
<td>List cultural or religious beliefs that may impact your care: ____________________________</td>
<td></td>
</tr>
<tr>
<td>How does child learn best? □ Written materials □ Verbal Discussion □ Video □ ____________________________</td>
<td></td>
</tr>
<tr>
<td>Does child have difficulty with? (Circle all that apply) Listening-Reading-Writing-Hearing-Seeing-Understanding</td>
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<tr>
<td>Person completing this form: ____________________________ Relationship to Child ____________________________</td>
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<tr>
<td>Parent’s Marital Status (if applicable): □ Single □ Married □ Divorced □ Widowed</td>
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<tr>
<td>Preferred method of communication: □ Phone □ Text □ Email Do you use: □ Computer □ Tablet □ Smart phone</td>
<td></td>
</tr>
<tr>
<td>How do you learn best? □ Written materials □ Verbal Discussion □ Video □ ____________________________</td>
<td></td>
</tr>
<tr>
<td>Do you have difficulty with? (Circle all that apply) Listening-Reading-Writing-Hearing-Seeing-Understanding</td>
<td></td>
</tr>
<tr>
<td>*Do you need help understanding instructions, pamphlets, or other written material from doctor or pharmacy? □ No - □ Sometimes - □ Always</td>
<td></td>
</tr>
<tr>
<td>Child’s typical weekday schedule: Lives with (including siblings): ____________________________</td>
<td></td>
</tr>
<tr>
<td>Sleep, School, (Work, Sports, Exercise type), schedule: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Describe any diabetes concerns with any of the above activities: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Child’s typical weekend schedule: Lives with (including siblings): ____________________________</td>
<td></td>
</tr>
<tr>
<td>Sleep, School, (Work Sports, Exercise type), schedule: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Describe any diabetes concerns with the above activities: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Does child use tobacco products? □ No □ Yes Type/Amount/Quit Date: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Does the child drink alcohol □ No □ Yes Type/Amount/Quit Date?</td>
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</tbody>
</table>

### Diabetes Distress Support/Healthy Coping

<table>
<thead>
<tr>
<th>Describe any stress with life the child is experiencing.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe any financial stress the family is experiencing.</td>
</tr>
<tr>
<td>In child’s own words what is diabetes?</td>
</tr>
</tbody>
</table>

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?

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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.

<table>
<thead>
<tr>
<th>Time</th>
<th>Basal Rate</th>
<th>Carb Ratio</th>
<th>Correction Factor</th>
<th>Glucose Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:00 am</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>
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 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 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 □ 1 time □ 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 □ 1 time □ 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: __________________________________________

*Indicates health literacy assessment item

<table>
<thead>
<tr>
<th>Time</th>
<th>Eats and Drinks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast</td>
<td></td>
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<tr>
<td>Snack</td>
<td></td>
</tr>
<tr>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>Snack</td>
<td></td>
</tr>
<tr>
<td>Dinner</td>
<td></td>
</tr>
<tr>
<td>Snack</td>
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</tbody>
</table>

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?