New West PHYSICIANS
Part of Optum®

DIABETES HEALTH QUESTIONNAIRE

Please assist us in serving you better by completing all sections below

Today's date:

Name: (last) (first) Birthdate: Years with diabetes:

Occupation: retired/unemployed — Work hours per week: swing or graveyard shift — Height: ft. in. — Weight: lbs. Desired weight: lbs.

Number of persons in household: Who assists you in emergencies? spouse/partner other family member friend/neighbor no one

Number of emergency room or hospital visits related to diabetes in last 5 years: Reason:

Psychological & Physical Wellbeing

Over the past two weeks have you felt down, depressed, and/or hopeless?
(0) Not at all (1) several days (2) more than ½ the days (3) nearly every day

Over the past two weeks have you felt little interest or pleasure in doing things?
(0) Not at all (1) several days (2) more than ½ the days (3) nearly every day

In general, would you say your health is: Excellent Very Good Good Fair Poor

Compared to one year ago, how would you rate your health in general now? Much better now than one year ago
Somewhat better now than one year ago About the same Somewhat worse now than one year ago Much worse than one year ago

What concerns you the most about your diabetes?

What is hardest in caring for your diabetes?

Other medical conditions None

Lifestyle

Exercise frequency: Never/seldom minutes times per week. Type of exercise:

Typical sleep: interrupted times a night; actual sleep: hours Naps: none about minutes per day

Tobacco/nicotine use per day: None e-cigarettes: cigarettes: dips/chews:

On a scale of 1 to 10, how ready are you to quit? (not at all) 1 2 3 4 5 6 7 8 9 10 (very much)

Marijuana use: None Medical Recreational; how much per day/week?

Number of alcoholic drinks per day week month, or year: Water intake: glasses or ounces per day

Number of meals per day: Which ones: breakfast lunch dinner/supper Snacks: AM PM Evening None

Special diet, if any: None Gluten free Paleo Ketogenic Vegetarian/vegan other:

Note barriers to purchasing healthy foods: None

More on reverse side

Medications/Insulin/Supplements & Monitoring

Do you take diabetes medications or insulin? Yes No If so which ones/types?

Do you ever skip diabetes medications/insulin? Yes No If yes, why? cost forget side effects I feel just fine without it

other:

Herbal or other supplements: None

What was the number of your last A1C?

What is your glucose range? When do you test your glucose? Never

How often do you have glucose readings below 70?

What symptoms to you have?

What do you do to treat low blood sugars?

How often do you have blood sugars greater than 200? Never

What symptoms, if any, do you have?

What do you do to treat high blood sugars?

Diabetes Complications

Diabetes complications you've experienced: eye problems protein in urine/kidney damage frequent urinary or yeast infections delayed digestion, diarrhea numbness, pain, tingling in hands or feet/nerve damage sexual dysfunction slow-healing sores heart attack/stroke none/I don't know

Goals & Learning Preferences

One or two of your health goals:

Steps you're taking to achieve your goal(s):

What do you most want to discuss during this visit/class?

What is your highest level of education?

Do you learn best by: reading watching doing listening

Is there anything else you'd like us to know?

On a scale of 1 to 10, how ready are you to make changes? (not at all) 1 2 3 4 5 6 7 8 9 10 (very much)

Clinician Assessment *Office use only*

Education needs/Education Plan:

Diabetes disease process Nutrition management Physical activity Using Medications Monitoring

Preventing acute complications Preventing chronic complications Behavior change strategies Risk reduction strategies

Psychosocial adjustment

Patient is scheduled for group classes in which all the above content areas will be covered MNT-focused visit d/t provider or patient request

Comments:

Date: Clinician:

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Diabetes and Nutrition Center Financial Policy

Notice of Financial Responsibilities

We will bill your insurance company for diabetes classes and individual appointments (also called diabetes self-management education/training and medical nutrition therapy, Diabetes Self-Management or Medical Nutrition Therapy). Some insurance plans do not cover these services.

If Diabetes Self-Management or Medical Nutrition Therapy are not covered benefits, payment will be the patient's responsibility. In that case, we will offer a 20% discount for services. If the desired service is a covered benefit applied to a deductible, no further discount will be applied.

We will not contact your insurance company to check for coverage. You may contact us if you need specific information for your insurance company.

If you do not have insurance, we apply a 20% discount when bill is paid in full at the time of service.

Out of Pocket Services

Please note some services are out of pocket-please ask for details

Co-Pay Policy

Diabetes Self-Management and Medical Nutrition Therapy may or may not require a co-payment by your insurance company. If they require a co-payment, you will receive a bill from New West Physicians.

Office visits require the usual co-pay listed on your insurance card for primary care.

Late Cancellation and No-Show Policy

We require at least 24 hours' notice for all cancelled appointments. **Appointments cancelled less than 24 hours prior to the scheduled time will be charged a $25.00 late cancellation fee, with exception to emergencies.**

Missed appointments without cancelation will be charged a $75.00 no-show fee.

Multiple missed or late canceled appointments may result in requesting a patient withhold rescheduling until their schedule permits time.

Notice of Privacy Practices

New West Diabetes and Nutrition Center adheres to all of the privacy practices of New West Physicians and the Health Insurance Portability and Accountability Act (HIPAA) affective April 14, 2003.

By signing this document, I acknowledge that I have read this document in full and understand and agree to the terms stated above.

______________________________ ______________
Signature-Patient/ Responsible Party Date

______________________________ ______________
Print patient name Date of Birth

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