Section 1—Demographic Information

Primary Care Physician:	How were you referred:	
Name (Last, First, M.I.):	A.K.A.:	
Date of Birth: / /	Age:	Gender: Male Female Transgender Other
Mailing Address:		
City:	State:	Zip Code:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
E-mail Address:	Do we have permission to contact you via e-mail? Yes No	

Primary Spoken Language: English Spanish Portuguese Other:	To which racial or ethnic group(s) do you *most* identify: African-American (non-Hispanic) Asian/Pacific Islanders Caucasian (non-Hispanic) Latino or Hispanic Native American or Aleut Other:

Marital Status: Single Partnered Married Separated Divorced Widowed	Full name of spouse or significant other:	
Employer Name:	Employer Address:	Occupation:
Employment Status (choose all that apply): Full-time Part-time Self-employed Not employed Retired Active Military		Driver's License Number:

Section 2—Emergency Contact Information

Contact Name:	Relation to Patient:	
Address:		
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )

Section 3—Insurance Information: if we have a copy of your Ins. card(s) skip this section

Primary Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Secondary Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Other Insurance:	Subscriber ID Number:
Group Number:	Group Name:

Complete the following questions if the subscriber is someone other than yourself, the patient.

Subscriber's Name:	Subscriber's Date of Birth: / /	Relation to Patient:
Address:		Subscriber's SSN:

Section 4—Consents

☐ I hereby certify that I am eligible for the health insurance plan I have listed in my registration form. I, also, certify that I have chosen The Priority Care Center to provide me with healthcare services. I understand that, were the aforementioned statement not true, I would be responsible for any and all charges for the services rendered. Additionally, if the aforementioned statement were not true, I agree to pay all charges, in their entirety, and within 90 days of receiving an invoice for services rendered at the Priority Care Center.

☐ I understand my rights that are referenced in the notice of Privacy Practices (a copy of this can be made available to you upon request).

☐ I give consent to for The Priority Care Center to obtain my prescription history.

Signature_____ Date_____/_____/_____

Name_____ DOB _____

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Name: _____ DOB: _____ Gender: ☐M ☐F

Primary Care Provider: _____

Preferred Pharmacy: _____Location: _____

CURRENT MEDICATIONS/SUPPLEMENTS (may bring own list to visit if you prefer) – this information may be taken directly from the pharmacy label on the prescription product.

Name of Medication	Strength of Medication	Dosing Instructions
Example: Tylenol	*Example: 500 mg*	*Example: 1 pill three times a day*

Past Medical History (Check all that apply)

☐ Acid Reflux/GERD	□ Chronic Pain	□ High Blood Pressure
□ ADHD	□ Depression	□ High Cholesterol
□ Alcoholism	□ Diabetes	□ Irritable Bowel
□ Allergies	□ Emphysema/Bronchitis/COPD	□ Kidney Disease
□ Anemia	□ Epilepsy/Seizure Disorder	□ Liver Disease
□ Anxiety	□ Glaucoma/Cataracts	☐Osteoporosis
□ Arthritis	□ Headaches	□ Stroke
□ Asthma	□ Hearing Loss	□ Thyroid Disease
☐ Bleeding Disorders	□ Heart Disease	□ Other: _____
□ Cancer		

Allergies

□ No Known Allergies	□ Medication Allergies	□ Environmental/ Seasonal Allergies	□ Latex Allergy

List Allergies	Reaction

Name_____ DOB _____

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Past Surgical History

Date of Surgery	Type of Surgery

Family Medical History

Members	Status (Alive/Deceased)	Diabetes	High blood pressure	Heart Disease	Mental Illness	Cancer (Type)	High cholesterol	Unknown
Father								
Mother								
Paternal Grandfather								
Paternal Grandmother								
Maternal Grandfather								
Maternal Grandmother								
Siblings								
Children								

Social History

Tobacco Use: Current use: ☐Yes ☐No
Past Use: ☐Yes ☐No When did you quit? _____
Type: ☐Cigarettes ☐Cigars ☐Chew ☐E-cigarette
Recreational Drug Use: ☐Yes ☐No
Type: ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamine ☐Other_____
Alcohol Use: ☐Daily ☐4-5 times per week ☐1-3 times per week ☐less than one time per week ☐none
Type: ☐Beer ☐Wine ☐Liquor
Marital Status: ☐Married ☐Separated ☐Divorced ☐Domestic Partnership ☐Single ☐Widow/Widower
Living Situation: ☐Own ☐Rent ☐Homeless ☐Other _____
Children: ☐Yes ☐No if yes, do they live with you ☐Yes ☐No
Support Network: ☐Spouse/Significant other ☐Family ☐Friends ☐Counselor ☐Other _____
Diet/Exercise: Are you on a special diet? ☐Yes ☐No if yes, what type _____
Do you Exercise? ☐Yes ☐No If yes, how often ☐Daily ☐3-5 days per week
☐1-2 days per week ☐less than once per week
What type _____

Name_____ DOB _____

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Do you have an Advance Directive in place?
☐Living Will ☐Durable Power of Attorney ☐Advanced Directive ☐POLST ☐None

HEALTH MAINTENANCE

Please provide the dates and results of the following immunizations, examinations, and tests to the best of your ability. If you have not had one of these services please indicate N/A (not applicable).

All Patients			
Last Tetanus Booster	□ Within past 10 years	□ More than 10 years ago	□ Unknown
Last Eye Exam (Dilated or Retinal) Last Hearing Exam Last Dental Exam Last Foot Exam	Date: _____ Date: _____ Date: _____ Date: _____	□ Normal □ Abnormal □ Normal □ Abnormal □ Normal □ Abnormal □ Normal □ Abnormal	□ Unknown □ Unknown □ Unknown □ Unknown
Last colonoscopy/ sigmoidoscopy/Or stool test	Date: _____	□ Normal □ Abnormal	□ Unknown
Last DEXA Bone Scan Last Pneumonia Vaccine Flu shot this season?	Date: _____ Date: _____ □ Yes □ No	□ Normal □ Abnormal	□ Unknown
Women Only			
Last Pap Smear	Date: _____	□ Normal □ Abnormal	□ Unknown
Last Mammogram	Date:	□ Normal □ Abnormal	□ Unknown

Concerns
Please indicate any concerns regarding your health in the space provided

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NAME: _____

Date: _____

PHQ-9	*Over the **last 2 weeks** how often have you been bothered by any of the following problems?*	*not at all*	*several days*	*more than half the days*	*nearly every day*
1.	Little interest or pleasure in doing things	*0*	*1*	*2*	*3*
2.	Feeling down, depressed, or hopeless	*0*	*1*	*2*	*3*
3.	Trouble falling or staying asleep, or sleeping too much	*0*	*1*	*2*	*3*
4.	Feeling tired or having little energy	*0*	*1*	*2*	*3*
5.	Poor appetite or overeating	*0*	*1*	*2*	*3*
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	*0*	*1*	*2*	*3*
7.	Trouble concentrating on things, such as reading the newspaper or watching television	*0*	*1*	*2*	*3*
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	*0*	*1*	*2*	*3*
9.	Thoughts that you would be better off dead or of hurting yourself in some way	*0*	*1*	*2*	*3*
	PHQ-9 total score =				

Would you like someone from our office to contact you before your appointment regarding any of the above?

____Yes _____No

Are you currently undergoing any treatment for depression?

□ **Medications:** _____

□ **Counselor:** _____

□ **Other:** _____

Client Name: _____ DOB: _____ Date obtained: _____

(PROMIS) Patient Reported Outcomes Measurement Information System is a system of highly reliable, precise measures of patient–reported health status for physical, mental, and social well–being. PROMIS tools measure what patients are able to do and how they feel by asking questions.

Global Health Assessment

Please respond to each item by marking one box per row. (NOTE: One or more missing responses will render such scoring unusable).

Questions	Excellent (5)	Very Good (4)	Good (3)	Fair (2)	Poor (1)
Global 01: In General, would you say your health is					
Global 02: In general, would you say your quality of life is					
Global 03: In general, how would you rate your physical health?					
Global 04: In general, how would you rate your mental health, including your mood and your ability to think?					
Global 05: In general, how would you rate your satisfaction with your social activities and relationships?					
Global 09: In general, please rate how well you carry out your usual social activities and roles (this includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.					
	Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global 06: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?					
	Never	**Rarely**	**Sometimes**	**Often**	**Always**
Global 10: In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?					
	None	**Mild**	**Moderate**	**Severe**	**Very Severe**
Global 08: How would you rate your fatigue on Average?					
Global 07: How would you rate your pain on average?	☐ 0	☐ 1 ☐ 2 ☐ 3	☐ 4 ☐ 5 ☐ 6	☐ 7 ☐ 8 ☐ 9	☐ 10
To be completed by staff: Total Score (G03, 06, 07, 08) Total Score (G02, 04, 05, 10)					_____

ADULT DIABETES HISTORY

Name:

DOB:

MR#: HCL#:

Attach label or addressograph

Date of Diagnosis

Pharmacy Name | Pharmacy Phone

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Cohabitating

in household | Relationship

Will significant others participate in program?
☐ No ☐ Yes ▶ Relationships: Names:

Race / Ethnicity (check all that apply)
☐ White ☐ Native American ☐ Black or African American ☐ Multi-race
☐ Asian ☐ Hispanic/Latino ☐ Native Hawaiian or other Pacific Islander

What level of schooling have you completed?
☐ Elementary school ☐ High school diploma ☐ Some college ☐ College/University degree
☐ Technical/Vocational/Business ☐ Military training ☐ Graduate school ☐ Other: _____

Occupation
☐ Managerial/Professional ☐ Skilled labor ☐ Military ☐ Unemployed
☐ Technical/Sales/Clerical ☐ Other labor ☐ Student ☐ Other: _____
☐ Education/Teacher ☐ Homemaker ☐ Retiree _____

Is your job physically active or inactive?
☐ Active ☐ Inactive

Primary/Referring Physician | Phone

Physician's Address

Have you had diabetes education?
☐ No ☐ Yes ▶ Where? _____ Date: _____

Do you have specific educational needs?
☐ No ☐ Yes ▶ What kind? _____

Do you have any medication allergies?
☐ No ☐ Yes ▶ What kind? _____

Have you ever been diagnosed with any of the following conditions, or do you have a concern?

Diagnosed	Concern		Diagnosed	Concern		Diagnosed	Concern	
☐	☐	High blood pressure	☐	☐	Thyroid disease	☐	☐	Stomach or bowel problems
☐	☐	Heart disease	☐	☐	Eye or vision problems	☐	☐	Depression
☐	☐	Abnormal blood lipids (fats)	☐	☐	Kidney disease			
☐	☐	Circulation problems	☐	☐	Skin			
☐	☐	Numbness/pain (hands/legs/feet)	☐	☐	Dental or mouth problems			
☐	☐	Foot problems	☐	☐	Liver disease			

Family History of:
Diabetes ☐ No ☐ Yes
Thyroid disease ☐ No ☐ Yes
Heart disease ☐ No ☐ Yes

List past surgeries and/or hospitalizations with dates:
Surgery/Hospitalization: _____ Date: _____
Surgery/Hospitalization: _____ Date: _____
Surgery/Hospitalization: _____ Date: _____
Surgery/Hospitalization: _____ Date: _____

Date of last eye exam | Date of last dental exam | Date of last foot exam

If you are female:
Are you pregnant? ☐ No ☐ Yes
Are you considering pregnancy? ☐ No ☐ Yes
Are you currently using birth control? ☐ N/A ☐ No ☐ Yes Type of birth control: _____
Are your menstrual cycles regular? ☐ N/A ☐ No ☐ Yes If no, explain: _____

NUTRITION AND LIFESTYLE HISTORY

What food-planning methods have you followed in the past? (check all that apply)

☐ Calorie counting ☐ Carbohydrate counting ☐ Low carbohydrate ☐ Exchange lists ☐ Fat-gram counting ☐ Food pyramid / Healthy choices ☐ No added sugar ☐ No method taught ☐ Other: _____

What method of diabetes food planning (if any) are you currently using?

How often do you follow a diabetes food plan?
☐ 0 ☐ 1–25% ☐ 26–50% ☐ 51–75% ☐ >75%

Typical Day Schedule: Please fill in the **times** of your meals and snacks, along with an example of the **type and amount** of food you might eat for your meals and snacks.

	TIME	TYPICAL MEALS - Example of 1 typical day
I get up at		
Breakfast		Breakfast:
Morning snack		Morning snack:
Midday meal		Midday meal:
Afternoon snack		Afternoon snack:
Evening meal		Evening meal:
Bedtime or bedtime snack		Bedtime or bedtime snack:
I go to bed at		

Do you exercise?
☐ No ☐ Yes ▶ What type(s)? ☐ Walking ☐ Biking ☐ Active job ☐ Swimming ☐ Sports ☐ Aerobic machine ☐ Other: _____

How many times per week do you exercise?
☐ 0 ☐ 1–2 ☐ 3–4 ☐ 5–6 ☐ more than 6

For how many minutes per time?
☐ 0 ☐ 1–10 ☐ 11–15 ☐ 16–30 ☐ more than 30

Have you ever been advised by a physician to limit your exercise in any way?
☐ No ☐ Yes ▶ Explain: _____

Outside work, how many minutes a day are you physically active?

Has your weight changed in the past year?
☐ No ☐ Yes ▶ How much? _____ ☐ Gain ☐ Loss

Do you drink alcohol?
☐ No ☐ Yes ▶ Type(s), amount, and times per week: _____

Do you use tobacco?
☐ No ☐ Yes ▶ Type: _____ Amount per day: _____

Former tobacco user?
☐ No ☐ Yes ▶ Quit date? _____

Do you use street drugs?
☐ No ☐ Yes

List all of your medications including over-the-counter medications and vitamin/mineral supplements:

_____

_____

_____

ORAL DIABETES MEDICATIONS / NONINSULIN INJECTABLE

START DATE	NAME	DOSE	TIME OF DAY	SIDE EFFECTS?
				☐ No ☐ Yes ▶ Describe:
				☐ No ☐ Yes ▶ Describe:
				☐ No ☐ Yes ▶ Describe:

INSULIN

Insulin Doses (pump users, see below): Please circle the types of insulin you are taking and write down your current insulin doses.

	BREAKFAST	MIDDAY MEAL	EVENING MEAL	BEDTIME	SNACKS
Regular Apidra® (glulisine) Humalog® (lispro) NovoLog® (aspart)					
NPH Lantus® (glargine) Levemir® (detemir)					
70/30 (with aspart) 70/30 (with Regular) 75/25 (with lispro) 50/50 (with lispro) 50/50 (with Regular)					

Pump Users: Please write down all of your bolus and basal rates and carbohydrates for the last 24 hours.

TIME	12 AM	1	2	3	4	5	6	7	8	9	10	11	12 PM	1	2	3	4	5	6	7	8	9	10	11	
Carbs																									Total Carbs
Bolus																									Total Bolus
Basal																									Total Basal

If you take insulin, please answer the following:

Are you using an insulin-to-carbohydrate ratio?
☐ No ☐ Yes ▶ What is the ratio? _____ Units of insulin per _____ grams of carbohydrate

Do you supplement with extra insulin when your blood glucose is high (sliding scale)?
☐ No ☐ Yes ▶ Fill in the scale you use in the table to the right.

Injection sites
☐ Stomach ☐ Arm ☐ Leg ☐ Buttocks

Where do you store unopened insulin?

Where do you store insulin currently in use?

Do you use an insulin pen?
☐ No ☐ Yes

Where do you dispose of needles/syringes/lancets?

Supplemental Scale (correction factor)

Blood Glucose	+ Insulin

BLOOD GLUCOSE MONITORING

Are you testing your blood glucose (sugar)?
☐ No ☐ Yes ▶ When? _____

What type of meter do you use?

What time(s) of the day do you test?

Do you have a target blood glucose range?
☐ No ☐ Yes ▶ What is it? _____ mg/dL to _____ mg/dL

Do you know your last A1C?
☐ No ☐ Yes ▶ Result: _____ Date: _____

Do you have a target A1C?
☐ No ☐ Yes ▶ What is it? _____

Do you ever check for ketones?
☐ No ☐ Yes ▶ When? _____

Do you use foil-wrapped ketone strips?
☐ No ☐ Yes

HYPOGLYCEMIA

Do you experience low blood glucose (hypoglycemia)?
☐ No ☐ Yes ▶ What time of day does it occur? _____ Do you require assistance from others? ☐ No ☐ Yes

Do you have lows that you don't feel?
☐ No ☐ Yes

Do you carry food to treat lows?
☐ No ☐ Yes ▶ What? _____

Do you wear medical ID?
☐ No ☐ Yes

Do you have a glucagon emergency kit?
☐ No ☐ Yes ▶ Expiration date: _____

LIFESTYLE AND BEHAVIORAL ASSESSMENT

Most Important Concerns

What do you feel are your most important concerns regarding your diabetes management?
What would you like to learn during your visits?
Did you require hospitalization at diagnosis? ☐ No ☐ Yes ▶ How long?

Check each of the items below that may concern you.

☐ 1. Do you have problems with sleeping (such as insomnia, sleep apnea, nightmares, or talking in your sleep)?

☐ 2. Do you have problems with eating or exercising (such as eating too little, overeating, or overexercising)?

☐ 3. Do you have problems with depression or noticeable mood changes (such as feeling sad, having mood swings, or experiencing increased irritability)?

☐ 4. Do you have problems with anxiety, nervousness, or stress (such as feeling worried all the time or overstressed)?

☐ 5. Do you have problems in social, school, or work environments (such as decreased productivity, avoidance, or withdrawal)?

☐ 6. Do you have problems with relationships with other people (such as friends, people at school, or people at work)?

☐ 7. Do you have problems within your family (such as conflict, marital conflict, or disciplining children)?

☐ 8. Do you have problems with certain kinds of inappropriate or undesirable behaviors (such as aggression, overactivity, repeating behaviors you do not want to repeat, or illegal behavior)?

☐ 9. Do you have problems with addictive behaviors (such as drug or alcohol abuse, gambling, or workaholic behavior)?

☐ 10. Do you have problems with sexual functioning (such as erectile dysfunction, vaginal dryness, or loss of desire)?

Concerns Specific to Diabetes

☐ 11. Do you have problems coping with diabetes (such as not being able to test your blood glucose or eat when you need to)?

☐ 12. Do you have problems within your family (such as not setting limits with family members regarding diabetes care)?

☐ 13. Do you have problems at work (such as getting time for diabetes care or experiencing discrimination because of diabetes)?

☐ 14. Do you have problems with relationships with other people (such as eating or testing in front of others)?

☐ 15. Have you ever been involved in therapy with a psychologist, counselor, or social worker?

☐ No ☐ Yes ▶For what? _____

When? _____

With whom? _____

What was helpful? _____

What was not helpful? _____

Who completed this form?	Relationship to Patient
Signature	

FOR HEALTH PROFESSIONAL USE

☐ Referral made and accepted

☐ Referral made and refused

☐ Referral pending

Type 2 Diabetes

Basics

Knowledge Test

Name: _____ Date: _____

Circle one: Session 1 Session 2 Session 3 Session 4

Directions: Read each question and decide which choice *best* completes the statement or answers the question. Indicate your answer by circling the appropriate letter.

1. Risk factors for type 2 diabetes include:
   a. Eating high-sugar foods and sweets
   b. High levels of physical activity
   c. A family history of diabetes
   d. An immune system that is working too hard
   e. I don't know

2. If at least half (50%) of your blood glucose levels are in the recommended target ranges (70-130 mg/dL before meals, less than 180 mg/dL 1-2 hours after meals), your A1C test should be:
   a. Less than 6%
   b. Less than 7%
   c. Less than 8%
   d. Less than 9 %
   e. I don't know

3. When diabetes starts, why do people with type 2 diabetes have high blood glucose levels?
   a. The pancreas has completely stopped making insulin
   b. The kidneys are not working properly
   c. The body cannot use insulin properly or the pancreas does not make enough insulin
   d. The sweets they ate caused diabetes
   e. I don't know

4. A common symptom of diabetes is:
   a. Weight gain
   b. Fatigue
   c. Rash
   d. Craving for sweets
   e. I don't know

5. One carbohydrate choice contains:
   a. 5 grams of carbohydrate
   b. 15 grams of carbohydrate
   c. 25 grams of carbohydrate
   d. 50 grams of carbohydrate
   e. I don't know

Type 2 Diabetes

Basics

Knowledge Test

6. The following is true about fat in foods:
   a. Fat can cause blood glucose to go up
   b. A high-fat diet can help with weight loss
   c. Fat should be counted as a carbohydrate choice
   d. Certain kinds of fat can increase the risk of heart disease
   e. I don't know

7. Mary had a sandwich made of 2 slices of wheat bread, 2 ounces of turkey, and 1 teaspoon of mayonnaise for lunch. She also had a small apple and 1 cup of skim milk. How many carbohydrate choices did Mary have?
   a. 3
   b. 4
   c. 6
   d. 7
   e. I don't know

8. How does physical activity usually affect blood glucose levels?
   a. Lowers blood glucose
   b. Raises blood glucose
   c. Has little effect on blood glucose
   d. None of the above
   e. I don't know

9. Creating a Diabetes Success Plan (goal setting) is a way to help you make positive lifestyle changes. Which plan below is an example of a practical plan?
   a. If you have never exercised: "I will jog 5 miles, 5 days a week."
   b. "I will lose 30 pounds in 2 months."
   a. If you are currently exercising: "I will increase the time I currently exercise by 5 or more minutes each session."
   c. "I will never forget to take my diabetes medication."
   d. I don't know

10. Symptoms of low blood glucose include:
    a. Feeling shaky or sweaty
    b. Dry skin
    c. Feeling energetic
    d. Dry mouth
    e. I don't know

11. A good treatment for hypoglycemia is:
    a. ½ cup orange juice
    b. 1 can regular soft drink
    c. 1 full-size candy bar
    d. 1 ounce peanuts
    e. I don't know

Type 2 Diabetes

Basics

Knowledge Test

12. Illness and emotional stress generally cause your blood glucose levels to:
    a. Increase
    b. Decrease
    c. Stay the same
    d. None of the above
    e. I don't know

13. Which of the following is not a complication of diabetes?
    a. Kidney problems
    b. Lung problems
    c. Nerve problems
    d. Heart problems
    e. I don't know

14. Good foot care for people with diabetes includes:
    a. Aggressively removing corns and calluses
    b. Soaking the feet
    c. Going barefoot in your house
    d. Checking your feet daily
    a. e,. I don't know

15. Some diabetes pills:
    a. Resist the action of insulin
    b. Help your body use insulin better
    c. Contain insulin
    d. None of the above
    e. I don't know