Diabetes Community Center
TEACHING HEALTH...CREATING HOPE

731 North Weber. Suite 235 Colorado Springs, CO 80903 P: 719-473-7808 F: 719-473-4877 E: info@dcccolorado.org

PREDIABETES
CLIENT REGISTRATION

DATE:_____

PERSONAL INFO: EMAIL:_____
Do you give DCC permission to use your email for general communication (you will only see your email address)? Yes ☐ No ☐

LAST NAME: _____ FIRST NAME: _____DOB:_____AGE:_____
ADDRESS:_____CITY:_____STATE_____ZIP: _____
HOME PHONE:_____WORK:_____CELL: _____
OCCUPATION:_____LEVEL OF EDUCATION:_____
EMERGENCY CONTACT (& title)_____PHONE: _____
MARITAL STATUS:_____PRIMARY SUPPORT PERSON(S):_____

PHYSICIAN INFO: PRIMARY CARE:_____PHONE:_____
REFFERRING PHYSICIAN:_____ PHONE:_____

MEDICAL INFO:
Prediabetes Info: Date of diagnosis: _____ Age of diagnosis: _____ Not yet diagnosed: _____
Have you had any prediabetes education in the past? Yes _____ No _____ If yes, how long ago was it? _____
Other health diagnoses:_____
Monitoring & Medications:
Prediabetes Meds type and dose: _____
Other Meds names and doses: _____
Have you had an HbA1c? Yes □ No□ If so, when? _____ What was it? _____
Complications: (check any that apply)
Have you ever experienced low blood sugars?_____High blood sugars?_____
High Blood Pressure? _____ High Triglycerides? _____ High LDLs ("bad" cholesterol)? _____

ADDITIONAL INFO:
Lifestyle Habits:
Do you exercise regularly? Yes _____ No _____ What kind of exercise and duration?_____ Times a week? _____
Do you smoke? Yes ___ No ___ If yes, how much? _____ Do you drink alcohol? Yes ___ No ___ If yes, how often? _____
Teaching Plan:
What are your educational goals pertaining to prediabetes? _____
What is your preferred method of learning? (ex: demonstration, reading, etc): _____
Do you have any barriers to learning? (ex: visual, language, etc): _____
Any additional comments:_____

Client Signature: _____ **Date:** _____

Diabetes Educator: _____ **Date:**_____