THE CASON GROUP

DIABETES

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. Date first diagnosed: _____

2. How often does your client visit his/her physician? _____
   When was the last visit? _____

3. The client's diabetes is controlled by:
   - ☐ diet alone
   - ☐ oral medication (medication and doses) _____
   - ☐ insulin (amount and units/day) _____

4. Is client on any other medications?
   - ☐ no
   - ☐ yes; please give details:

5. Please give the most recent blood sugar reading: _____

6. Does client monitor his/her own blood sugar? _____

7. If available, please give the most recent glycohemoglobin (BhA1C) or fructosamine level: _____

8. Please check if your client has (had) any of the following:
   - ☐ chest pain or coronary artery disease
   - ☐ protein in the urine
   - ☐ neuropathy
   - ☐ abnormal ECG
   - ☐ elevated lipids
   - ☐ kidney disease
   - ☐ hypertension
   - ☐ overweight
   - ☐ retinopathy

9. Does client have any other health issues?
   - ☐ no
   - ☐ yes; please give details (another questionnaire may be necessary)