

Diabetes Self-Management Education Workshop Registration

Workshop Registration/Completed by participant.



A Stanford University Self-Management Program

All information will be kept confidential.

First Name _____ Last Name _____

Address _____

City _____ Zip _____ County _____

Phone Number _____ Cell Phone Home Phone Work Phone

Email _____

How did you hear about class? *(Check as many as you want)*

- Senior Center My doctor A friend or family member
 The building where I live Church Poster, flier, or mailing
 Ad in magazine Other (tell us what) _____

Gender Male Female

Birth Date _____

(Month, Day, Year) Example: 01/16/1965

Please identify your race *(optional)*

- American Indian or Alaska Native Asian Black or African American
 Native Hawaiian or Other Pacific Islander White Other _____

Please identify your ethnicity *(optional)*

- Hispanic or Latino Not Hispanic or Latino

Do you speak a language other than English at home?

- Yes No
 Spanish Chinese Korean
 Other language (tell us) _____

Education Completed

- 8th Grade or Less Some High School High School Diploma Some College or Technical School
 College or Beyond Graduate or Professional Degree Unknown

What type of insurance do you have? *Select all that apply.*

- Medicare Medicare ID # _____ Medicaid
 Private/Employer I don't have insurance I don't know



Do you smoke?

- Yes No

Please Select One

- I Have a Chronic Condition I am a Caregiver

Please check all that apply

- | | | |
|---|--|---|
| <input type="checkbox"/> Alzheimer's or Related Dementia | <input type="checkbox"/> Arthritis/Rheumatic Disease | <input type="checkbox"/> Breathing/Lung Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression or Anxiety Disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Eye Disease (such as retinopathy) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Hypertension (high blood pressure) | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Osteoporosis (low bone density) | <input type="checkbox"/> Stroke | <input type="checkbox"/> None |
| <input type="checkbox"/> Other Chronic Condition _____ | | |

What kind of diabetes do you have?

- Pre-diabetes Type 1 diabetes Type 2 diabetes
 I don't have diabetes I don't know

When did your doctor tell you that you have diabetes or pre-diabetes?

- Less than one year ago Less than two years ago Less than three years ago
 Less than four years ago Four or more years ago I don't know/I don't remember

In the last year, about how many times has a doctor or nurse checked your feet?

- Write number of times _____ Never Don't know or not sure

Have you completed a self-management workshop before? No Yes

Have you completed a diabetes self-management workshop before? No Yes
 Don't know or not sure

How would you rate your overall quality of life?

0 1 2 3 4 5 6 7 8 9 10
Poor Quality *Excellent Quality*

In general, how would you describe your health?

- Poor Fair Good Very Good

What is your preferred method of contact?

- Mail Phone Email

