Lifestyle Change Program Intake Form

Today's Date *(mm/dd/yyyy)*: _____

First Name:	**Last Name:**
E-mail Address:	**Phone Number**: _____-_____-_____
Date of Birth *(mm/dd/yyyy)*: _____/_____/_____	**Gender** *(check one)*: ☐ Male ☐ Female
State of Residency:	**Ethnicity** (*check one*): ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Race (*check all that apply):* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White	
Height: _____ feet _____ inches	**Starting Weight** *(weight taken today):* _____ pounds *(round to nearest pound)*

Have you been told by a health care provider that you have prediabetes, elevated blood sugar, or borderline diabetes? *(check one)*:

☐ Yes ☐ No

<u>If yes</u>, what type of blood test was performed? *(check all that apply)*

- ☐ Finger prick blood test
- ☐ Fasting glucose test (blood test where blood was drawn with needle)
- ☐ Hemoglobin A1c test
- ☐ Oral Glucose Tolerance Test
- ☐ Don't know / don't remember

Do you have a primary care provider?

☐ Yes ☐ No

<u>If yes</u>, who? _____

<u>If you are a woman</u>, have you ever been told by a health care provider that you had Gestational Diabetes Mellitus (GDM) during pregnancy? *(check one)*:

☐ Yes ☐ No