

Physical Activity Assessment and Documentation Form

Name: _____ Date: _____ MR# _____

D.O.B.: _____ / Age: _____ Visit length (minutes): _____

Patient's Physical Activity Goal/Reason for Visit:

Current Activity/Exercise: (describe mode, frequency, intensity and duration):

Past Participation: _____

Barriers to Physical Activity: (check all that apply)

Lack of time/support

Energy

Money

Other medical issues

Fear of low blood glucose

Other

Comments: _____

Occupation: _____ **Recreational Activity:** _____

Home Exercise Equipment: _____

Concerns about Physical Activity: _____

Favorite Activities: _____

Hx of Hypoglycemia: Yes No **Associated with:** _____

Adjustments for Exercise: _____

Objective:

HR: _____

RBP: Sitting: ____/____

Standing: ____/____

Ht: _____

Wt: _____ BMI: _____

Waist Circumference: _____

Date of DM Diagnosis: _____

Date/Result: Last A1C: ____/____ Total Cholesterol: ____/____

LDL Chol: ____/____ HDL Chol: ____/____

Triglycerides: ____/____ Microalb/Cr Ratio ____/____

Insulin Doses: Brk _____ Lunch _____ Dinner _____ Bedtime _____

Oral Agent Doses:

Diabetes Complications: (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Hx of Foot Ulcer | <input type="checkbox"/> Orthostatic Hypotension |
| <input type="checkbox"/> Cerebrovascular Disease | <input type="checkbox"/> Other _____ | |

Last dilated eye exam: _____

Last foot exam: _____

Last stress test: _____ Results: _____

- | | | |
|--|------------------------------|-----------------------------|
| Patient recognizes the importance of physical activity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Patient is at risk for low blood glucose with physical activity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Current Activity meeting their personal health goals | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Assessment: _____

Plan:

Counseled on:

- | | |
|--|---|
| <input type="checkbox"/> Importance of physical activity in diabetes | <input type="checkbox"/> Snacking guidelines |
| <input type="checkbox"/> How to adjust insulin for activity | <input type="checkbox"/> Physical activity BG goals |
| <input type="checkbox"/> Weight management & physical activity | <input type="checkbox"/> Checking pre & post activity |

Pt plans to: _____ Perform _____ on _____ for _____
(activity) (days of week) (duration in minutes)

- Obtain medical clearance prior to starting an exercise program
- Continue their current activity
- Buy a pedometer _____
- Return for follow up appointment in _____ to assess progress towards goal
(weeks)

Exercise Prescription: _____

Educator's Signature: _____ **Date:** _____