**Today’s Date** *(mm/dd/yyyy)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Name:** | **Age:** |
| **E-mail Address**: **Preferred Phone Number**:\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_**Do you prefer texting**? \_\_ Yes \_\_ NoIf so, provide your cell number\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ | **Who is the primary payer for your participation in this National DPP Lifestyle Change Program? (Choose one)**\_\_\_ Medicare \_\_\_ Dual eligible\_\_\_ Medicaid \_\_\_ Grant Funding\_\_\_ Private Insurer \_\_\_ Employer\_\_\_ Self-pay \_\_\_ Free of charge \_\_\_ Other |
| **Who or What *motivated* you the most to sign up for this program; what was the most influential factor? Check one**\_\_\_ Healthcare professional \_\_\_ Blood test result\_\_\_ Prediabetes risk test \_\_\_ Someone at community-based organization (church, community center, fitness center) \_\_\_ Family/friends \_\_\_ Current or past participant in National DPP LCP\_\_\_ Employer or employer’s wellness plan \_\_\_Health insurance plan\_\_\_ Media advertisement (social media, flyer, brochure, radio ad, billboard, newspaper ad) | **Did a healthcare professional ask you to join the program?**\_\_\_ Yes, a doctor/doctor’s office\_\_\_ Yes, a pharmacist\_\_\_ Yes, other healthcare professional\_\_\_ No**What is your highest education level?**\_\_\_ Less than grade 12 (no high school diploma or GED)\_\_\_ Grad 12 or GED\_\_\_ Some college or technical school\_\_\_ College or technical school graduate or higher |
| **Sex**  What sex were you assigned at birth? \_\_\_ Male \_\_\_\_ Female \_\_\_ Do not wish to report | **Gender** What genderidentity do you most identify with?, (check one)\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Transgender \_\_\_ Do not wish to report |
| **Race** (*check all that apply):*\_\_\_\_\_ American Indian or Alaska Native \_\_\_\_\_ Asian or Asian American \_\_\_\_\_ Black or African American\_\_\_\_\_ Native Hawaiian or Pacific Islander\_\_\_\_\_ White  | **Ethnicity** (*check one*):⎯⎯⎯ Hispanic or Latino \_\_\_\_\_\_ Not Hispanic or Latino |
| **Height:**\_\_\_\_\_\_ feet \_\_\_\_\_\_ inches | **Weight***:**\_\_\_\_\_\_\_\_* 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

**\* If yes*,* 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

**\* Please include a copy of your lab result with this form, if possible.**

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

\_\_\_\_\_ Yes \_\_\_\_\_ No