

Participant Enrollment Form

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

| | |
|---|--|
| First Name: | Last Name: |
| E-mail Address: | Phone Number: _____ - _____ - _____ |
| Address: Street: Apartment/ P.O Box: City: _____ County: _____ State: _____ Zip Code: _____ | |
| Date of Birth (mm/dd/yyyy): ____/____/____ | |
| Gender Identity (check one): <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender <input type="checkbox"/> Prefer not to answer | Sex assigned at birth (check one): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to answer |
| Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | Race (check all that apply): <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White |
| Ethnicity (check one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino | Education (check one): <input type="checkbox"/> Less than grade 12 (No high school or GED) <input type="checkbox"/> Grade 12 or GED (High school graduate) <input type="checkbox"/> Some College (1 year – 3 years) <input type="checkbox"/> College (4 years or more) |



| | |
|--|---|
| Enrollment Source (<i>check one</i>): | |
| <input type="checkbox"/> Non-primary healthcare professional | <input type="checkbox"/> Family/Friends |
| <input type="checkbox"/> Primary care provider | <input type="checkbox"/> An employer or employer's wellness program |
| <input type="checkbox"/> Community-based organization | <input type="checkbox"/> Insurance Company |
| <input type="checkbox"/> Self (<i>Decided to come on your own</i>) | <input type="checkbox"/> Media |
| | <input type="checkbox"/> Other _____ |
| Payer Type (<i>check one</i>): | |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Dual Eligible (Medicare and Medicaid) |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Grant Funding |
| <input type="checkbox"/> Private Insurer | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Self-pay | <input type="checkbox"/> Other _____ |
| Height: _____ feet _____ inches | Weight: _____ pounds (<i>round to nearest pound</i>) |

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 and what was the result? (*check all that apply*)

- Fasting glucose test (*blood test where blood was drawn with needle*)

- Hemoglobin A1c test _____
- Plasma glucose measured 2 hours a 75g glucose load _____
- Don't know / don't remember

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



Pre-Diabetes Risk Test

For each question, write the score that goes with your answer in each box. Your Lifestyle Coach will add up the points and talk to you about next steps.

Prediabetes Risk Test



1. How old are you?

- Younger than 40 years (0 points)
- 40–49 years (1 point)
- 50–59 years (2 points)
- 60 years or older (3 points)

Write your score in the boxes below

2. Are you a man or a woman?

- Man (1 point)
- Woman (0 points)

3. If you are a woman, have you ever been diagnosed with gestational diabetes?

- Yes (1 point)
- No (0 points)

4. Do you have a mother, father, sister, or brother with diabetes?

- Yes (1 point)
- No (0 points)

5. Have you ever been diagnosed with high blood pressure?

- Yes (1 point)
- No (0 points)

6. Are you physically active?

- Yes (0 points)
- No (1 point)

7. What is your weight category?

(See chart at right)

| Height | Weight (lbs.) | | |
|--------|---|-----------------|-----------------|
| 4'10" | 119-142 | 143-190 | 191+ |
| 4'11" | 124-147 | 148-197 | 198+ |
| 5'0" | 128-152 | 153-203 | 204+ |
| 5'1" | 132-157 | 158-210 | 211+ |
| 5'2" | 136-163 | 164-217 | 218+ |
| 5'3" | 141-168 | 169-224 | 225+ |
| 5'4" | 145-173 | 174-231 | 232+ |
| 5'5" | 150-179 | 180-239 | 240+ |
| 5'6" | 155-185 | 186-246 | 247+ |
| 5'7" | 159-190 | 191-254 | 255+ |
| 5'8" | 164-196 | 197-261 | 262+ |
| 5'9" | 169-202 | 203-269 | 270+ |
| 5'10" | 174-208 | 209-277 | 278+ |
| 5'11" | 179-214 | 215-285 | 286+ |
| 6'0" | 184-220 | 221-293 | 294+ |
| 6'1" | 189-226 | 227-301 | 302+ |
| 6'2" | 194-232 | 233-310 | 311+ |
| 6'3" | 200-239 | 240-318 | 319+ |
| 6'4" | 205-245 | 246-327 | 328+ |
| | 1 Point | 2 Points | 3 Points |
| | You weigh less than the 1 Point column (0 points) | | |



For Lifestyle Coach Use Only

Risk Score Total: _____ (high risk = 5 or more)

Eligible for Program (Yes or No)? _____

Assigned Participant ID # _____

Next Steps? _____

This risk test mirrors the 2019 version of the risk test provided by the ADA and CDC.



This document was created and adapted by DTTAC for use by organizations delivering the National Diabetes Prevention Program. For all other permissions, please contact dttac@emory.edu.

Questionnaire

Where am I right now?

Thinking about your eating habits and physical activity level in the past three months, please answer the questions below. This information will help your Lifestyle Coach to best support you on your lifestyle change journey.

1. How ready are you to make changes to your food choices? Mark/Circle how ready you feel.

← ————— ————— ————— →

Not prepared to change I want to change but I don't know how Planning to change Already changing

2. How ready are you to make changes to your physical activity levels (exercise)? Mark/Circle how ready you feel.

← ————— ————— ————— →

Not prepared to change I want to change but I don't know how Planning to change Already changing

3. Please explain what motivates you to participate in a Lifestyle Change Program.

- Health care professional
- Blood Test Results
- Prediabetes risk test (short survey)
- Someone at a community-based organization (church, community center, fitness center)
- Family or friends
- Current or past participant in the National DPP LCP
- Employer or employer's wellness plan
- Health insurance plan
- Media advertisements (social media, flyer, brochure, radio ad, billboard, etc.)

4. Did a Healthcare professional ask you to join this National DPP LCP?

- Yes, a doctor/ doctor's office
- Yes, a pharmacist
- Yes, other healthcare professional
- No



5. **On a scale from 1-10 how confident are you in your readiness to make lifestyle changes?**

[1=not confident, 10=very confident]

- 10- very confident
- 9
- 8
- 7
- 6
- 5
- 4
- 3
- 2
- 1- not confident

6. **What would help improve your confidence?**

7. **What are some challenges or barriers that you might face in your effort to make lifestyle changes?**

8. **What will help you overcome some of these challenges?**

9. **Please share anything else that you want us to know about your participation in the lifestyle change program:**

