



Queensland
Government

Diabetes Psychosocial Assessment

Facility:

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: ☐ M ☐ F ☐ I

Date: / /

Problem Areas in Diabetes (PAID) Questionnaire

Tick (✓) the number that gives the best answer for you. Please provide an answer for each question. Please bring the completed form with you to your next consultation where it will form the basis for a dialogue.

Which of the following diabetes issues are currently a problem for you?	Not a problem	Minor problem	Moderate problem	Somewhat serious problem	Serious problem
1. Not having clear and concrete goals for your diabetes care?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Feeling discouraged with your diabetes treatment plan?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Feeling scared when you think about living with diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Uncomfortable social situations related to your diabetes care (e.g. people telling you what to eat)?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Feelings of deprivation regarding food and meals?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Feeling depressed when you think about living with diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Not knowing if your mood or feelings are related to your diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. Feeling overwhelmed by your diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. Worrying about low blood sugar reactions?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10. Feeling angry when you think about living with diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
11. Feeling constantly concerned about food and eating?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
12. Worrying about the future and the possibility of serious complications?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
13. Feelings of guilt or anxiety when you get off track with your diabetes management?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
14. Not "accepting" your diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
15. Feeling unsatisfied with your diabetes physician?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
16. Feeling that diabetes is taking up too much of your mental and physical energy every day?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
17. Feeling alone with your diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
18. Feeling that your friends and family are not supportive of your diabetes management efforts?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
19. Coping with complications of diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
20. Feeling "burned out" by the constant effort needed to manage diabetes?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

DO NOT WRITE IN THIS BINDING MARGIN

v1.00 - 11/2020

WINC Code:



SW1065

DIABETES PSYCHOSOCIAL ASSESSMENT



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The following questions will assist us in determining which allied health service you may benefit from. Completion of this form is optional.

Do you have particular concerns or questions that you would like to be addressed today?

1.

2.

3.

Your Emotional Health

Over the past 2 weeks, how often have you been bothered by the following problems... (PHQ-4)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2. Not being able to stop or control worrying?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3. Little interest or pleasure in doing things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4. Feeling down, depressed or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Social support for life in general

	Strongly disagree	Disagree	Agree	Strongly agree
5. I can count on someone when things go wrong...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I can talk about my problems with someone...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your weight, shape and eating

On a scale of 1 to 5, where 5 is the best outcome

	1	2	3	4	5
7. I am comfortable with my current weight	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
8. I am comfortable with my body shape	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
9. I am comfortable with my eating pattern	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Financial Concerns

	Yes	No
10. Do you have a Medicare card?	<input type="checkbox"/>	<input type="checkbox"/>
11. Do you have a NDSS card?	<input type="checkbox"/>	<input type="checkbox"/>
12. Do you have a Health Care card?	<input type="checkbox"/>	<input type="checkbox"/>
13. Do you have difficulty managing your living costs on your current income?	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have difficulty managing your healthcare costs on your current income?	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have private health insurance?	<input type="checkbox"/>	<input type="checkbox"/>

Hypoglycaemia (hypo or low blood glucose)

16. I feel that I can't ever be safe from hypoglycaemia...	<input type="checkbox"/> Not a problem <input type="checkbox"/> Slight problem <input type="checkbox"/> Moderate problem	<input type="checkbox"/> Somewhat serious problem <input type="checkbox"/> Serious problem <input type="checkbox"/> Very serious problem
17. Do your hypo symptoms usually occur at a blood glucose level of...	<input type="checkbox"/> 3 or more mmol/L <input type="checkbox"/> Between 2.0–2.9mmol/L	<input type="checkbox"/> Less than 2mmol/L <input type="checkbox"/> I do not feel symptoms

Your Well-being (WHO-5)

Over the past 2 weeks...	All of the time	Most of the time	More than half the time	Less than half of the time	Some of the time	None of the time
18. I have felt cheerful and in good spirits	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
19. I have felt calm and relaxed	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
20. I have felt active and vigorous	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
21. I woke up feeling fresh and rested	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
22. My daily life has been filled with things that interest me	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0



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Health Record Audit

1. Type diabetes: ☐ T1DM ☐ T2DM ☐ LADA ☐ MODY ☐ Other (*specify*):

2. Year of diagnosis:

3. Diabetes medications – Insulin: ☐ OD ☐ BD ☐ MDI ☐ Pump ☐ Metformin

4. HbA1c: %: mmol/mol

5. BMI – Height: Weight: BMI:

6. Diabetic ketoacidosis (DKA) in the previous 2 years: ☐ Yes ☐ No

7. Serious hypoglycaemia episode in the previous 2 years: ☐ Yes ☐ No

8. Coeliac disease: ☐ Yes ☐ No

9. Addisons disease: ☐ Yes ☐ No

10. Thyroid disease: ☐ Yes ☐ No

11. Hypertension ☐ Yes ☐ No

12. Annual health review in the previous 2 years: ☐ Yes ☐ No

Was the patient seen by any of the following allied health in the previous 12 months:

13. Diabetes nurse educator: ☐ Yes ☐ No

14. Dietitian: ☐ Yes ☐ No

15. Psychologist: ☐ Yes ☐ No

16. External psychologist: ☐ Yes ☐ No

17. Psychiatrist: ☐ Yes ☐ No

Clinician name:

Designation:

Signature:

Date:

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