Course Evaluation Form

Name__________________________ Age__________________________
Address________________________ City__________________________
Phone__________________________ E-mail__________________________

1. My expectations for this course were:
   - [ ] Not met
   - [ ] Met
   - [ ] Exceeded

2. How much did you learn?
   Check the box you think best represents how much new information you learned about the components of diabetes self-management in this course.

   - How to make recipes healthier (Class 1) Did not attend
     - [ ] Nothing new
     - [ ] Very little new information
     - [ ] Quite a bit of new information
     - [ ] A great deal of new information

   - Use food labels and the exchange list to plan meals (Class 2) Did not attend
     - [ ] Nothing new
     - [ ] Very little new information
     - [ ] Quite a bit of new information
     - [ ] A great deal of new information

   - How to use herbs, spice and vegetables to flavor foods (Class 3) Did not attend
     - [ ] Nothing new
     - [ ] Very little new information
     - [ ] Quite a bit of new information
     - [ ] A great deal of new information

   - Portion size and what a portion looks like (Class 4) Did not attend
     - [ ] Nothing new
     - [ ] Very little new information
     - [ ] Quite a bit of new information
     - [ ] A great deal of new information
• How to get more fiber in your meal plan and why it is important
  ____ Nothing new
  ____ Very little new information
  ____ Quite a bit of new information
  ____ A great deal of new information

• The importance of eating a variety of fruits and vegetables to meet daily vitamin and mineral recommendations
  ____ Nothing new
  ____ Very little new information
  ____ Quite a bit of new information
  ____ A great deal of new information

3. As a result of participating in this class, did you make any changes in any of the following? Please check “yes” or “no”

• How you prepare recipes
  □ Yes
  □ No

• How you plan your meals
  □ Yes
  □ No

• More variety in the fruits and vegetables you eat
  □ Yes
  □ No

• Portion sizes
  □ Yes
  □ No

• Using herbs, spices, citrus and vegetables to flavor food
  □ Yes
  □ No

• Other (Please comment):

__________________________________________________________________________

__________________________________________________________________________

Whisking Your Way to Health
Cass Simmons
4. What information did you find most valuable?

5. I would improve this course by:

6. I would recommend this course to a friend:
   □ Yes          □ No

7. Other comments:

8. Rate Your Diabetes Management:

   Having diabetes means doing different tasks and activities to manage your blood sugar and reduce complications. How confident are you that you can plan healthy meals on a regular basis? (Circle the number that corresponds to your confidence that you can do the tasks regularly at the present time.)

   Not at all  1  2  3  4  5  6  7  8  9  10 Completely confident

certainly confident

9. In addition to any changes you may have already made, do you plan to make any changes as a result of this course?

   • Look at all the items below and Check all the boxes that apply to you. Leave it blank if this is not one of your goals.

   • For each box checked, circle a number from 1-10 that best describes your level of confidence to make that change.

   □ I will plan my healthy and balanced meals

   Please describe: __________________________________________

   As of right now, how confident are you that you can make this change?
Not at all 1 2 3 4 5 6 7 8 9 10 Completely confident

☐ I will use a shopping list for groceries

Please describe: __________________________________________

As of right now, how confident are you that you can make this change?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely confident

☐ I will use correct portion sizes for the foods I eat

Please describe: __________________________________________

As of right now, how confident are you that you can make this change?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely confident

☐ I will decrease the fats and/or sodium in my foods

Please describe: __________________________________________

As of right now, how confident are you that you can make this change?

Not at all 1 2 3 4 5 6 7 8 9 10 Completely confident

☐ I do not plan to make any changes.

Thank you! Please return this form to the instructor.

Whisking Your Way to Health
Cass, Simmons