**Supplementary File 1: Diabetes assessment**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate: D\_\_\_\_\_\_\_\_ M\_\_\_\_\_\_\_\_ Y\_\_\_\_\_\_\_\_ Male: \_\_\_\_\_\_\_\_ Female: \_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_

**I. Health History**

1. Number of years with Diabetes? \_\_\_\_\_\_\_\_\_ Type I­­\_\_ Type II\_\_
2. Do you check your blood glucose at home? No­­­\_\_ Yes\_\_ Do you have a meter at home?\_\_
3. How often do you check your blood glucose? \_\_\_\_\_\_\_\_\_\_ per day \_\_\_\_\_\_\_\_\_ per week
4. What is the range of your blood glucose test results (lowest to highest)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. Health History**

1. Hypertension No Yes Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Diagnosed Osteoporosis? No Yes Area affected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Muscle, or back rpoblem? No Yes Area affected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Angiogram No Yes If yes, findings: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Angioplasty No Yes Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Cardiac Related Surgery No Yes If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Heart Attack No Yes When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Broncho-Pulmonary (Asthma, COPD) No Yes Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Stroke No Yes
10. *Neuropathy*No Yes Area(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Ulcer No Yes Area(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
12. Ulcer History No Yes Area(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. Diabetes Medications**

1. A1C: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_
2. Glucose Levels:\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you take pills to control your diabetes? No Yes
4. Do you take insulin? No Yes
5. Type of insulin?
6. How much insulin do you take? (please list type and dosage)

**IV. Other Medications**

1. Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_Time(s) of Day: \_\_\_\_
2. Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_Time(s) of Day: \_\_\_\_
3. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_ Time(s) of Day: \_\_\_

**V. Current Status**

1. Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. A1C: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_
3. Glucose Levels:\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Lipid profile: Total: \_\_\_\_\_\_\_\_ HDL: \_\_\_\_\_\_\_\_ LDL: \_\_\_\_\_\_\_\_ Triglycerides: \_\_\_\_\_\_\_\_
5. VLDL: \_\_\_\_\_\_\_\_ Cholesterol: \_\_\_\_\_\_\_\_
6. Ankle/Brachial Ratio:\_\_\_\_\_\_/\_\_\_\_\_\_\_
7. Sat O2 left hand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sat O2 left foot:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. Romberg Test :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( Vestibular Problems Rule out)