NAME/ID:

DATE:

BASIS©

Current Weight:_____ ☐ kg ☐ lbs   Date checked: __________ ☐ n/a

Height:_____ ☐ feet/inches ☐ cm

*Body Mass Index (BMI):_____ *To be calculated by clinician

Blood Pressure:_____/_____ mmHg   Date checked: __________ ☐ n/a

Fasting Glucose:_____ ☐ mmol/L ☐ mg/dl   Date checked: __________ ☐ n/a

HbA1c:_____ %   Date checked: __________ ☐ n/a

We are interested in your own beliefs about your health. We are NOT interested in what others believe or may wish you to believe.

Indicate if you have any of the following health related experiences by reading the questions and marking ☒ either Yes or No.

	Yes	No
A) Do you regularly feel nervous?	☐	☐
B) Do you regularly sweat?	☐	☐
C) Do you regularly have difficulty sleeping?	☐	☐
D) Do you regularly have facial flushing? Do your cheeks get red?	☐	☐
E) Do you regularly have shortness of breath?	☐	☐
F) Do you regularly have headaches?	☐	☐
G) Do you regularly have nosebleeds?	☐	☐
H) Other: ____	☐	☐

☐ If 'NO' to ALL of the above, please go to the next page.

☐ If 'YES' to any of the above, indicate the extent to which you agree or disagree at the present moment with the following statement by circling the appropriate number, keeping in mind your health related experiences.

1) My health related experiences are due to having high blood pressure.

0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

Strongly Disagree	Moderately Disagree	Slightly Disagree	Unsure	Slightly Agree	Moderately Agree	Strongly Agree

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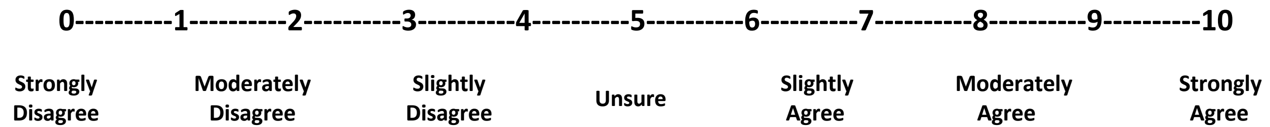
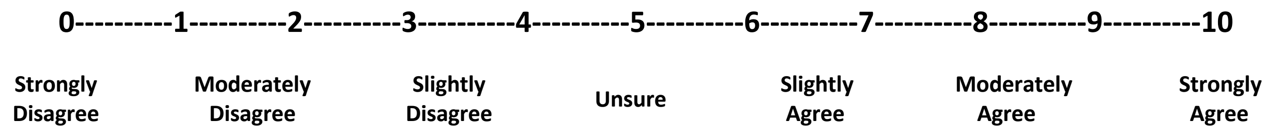
Please indicate the extent to which you agree or disagree at the present moment with each of the following statements by circling the appropriate number.

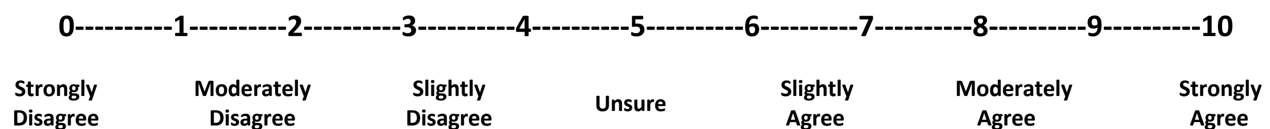
2) I have hypertension (i.e. high blood pressure).



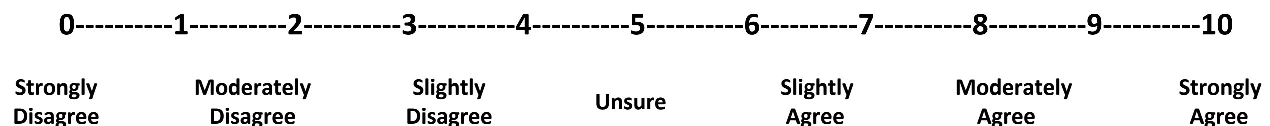
3) I NEED to make or maintain healthy life style changes to improve my diet and/or adjust the amount I exercise.



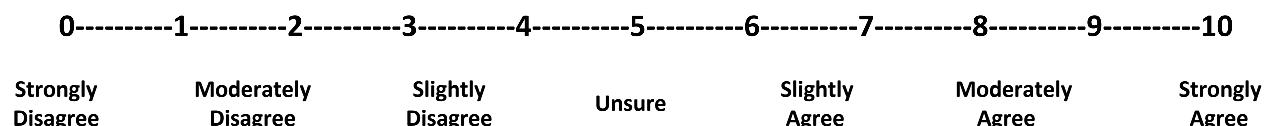
4) I have a normal blood pressure.*



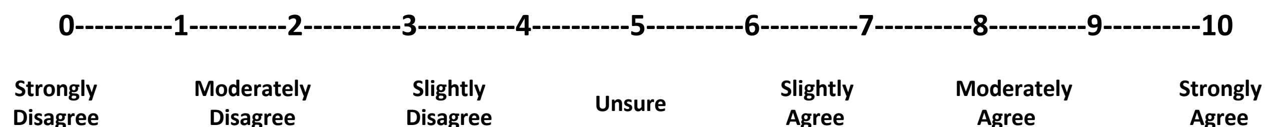
5) I can safely carry on my current lifestyle (i.e. eating/drinking and exercising as I currently do).*



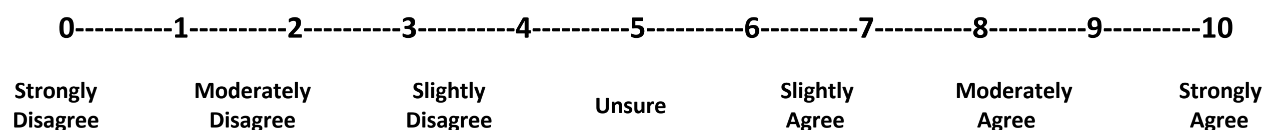
6) My high blood pressure has led or can lead to negative health consequences (e.g. heart disease, heart attack, heart failure, stroke, near stroke, kidney/renal disease, vision loss, etc.).



7) My blood pressure is regularly in the hypertensive range (i.e. ≥140/90).*



8) I need blood pressure lowering medication.



THE END

***See scoring sheet for applicability**

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