

NAME/ID:

DATE:

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.

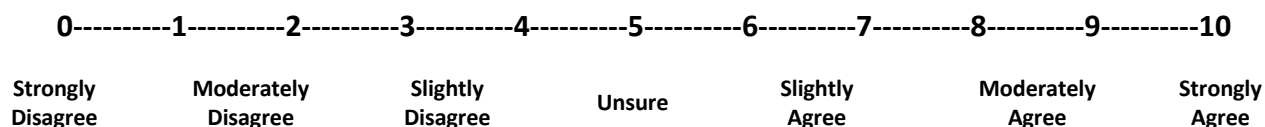
Indicate if you have any of the following health related experiences by reading the questions and marking either Yes or No.

	Yes	No
A) Are you regularly thirsty? Do you drink excessive amounts of water?	<input type="checkbox"/>	<input type="checkbox"/>
B) Do you urinate too frequently? Or do you have excessive amounts of urine?	<input type="checkbox"/>	<input type="checkbox"/>
C) Do you regularly wake up during the night to urinate?	<input type="checkbox"/>	<input type="checkbox"/>
D) Do you have blurred vision?	<input type="checkbox"/>	<input type="checkbox"/>
E) Have you lost a lot of weight?	<input type="checkbox"/>	<input type="checkbox"/>
F) Do you regularly feel fatigued?	<input type="checkbox"/>	<input type="checkbox"/>
G) Do you have numbness, tingling, burning or loss of sensation in your feet or hands?	<input type="checkbox"/>	<input type="checkbox"/>
H) Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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

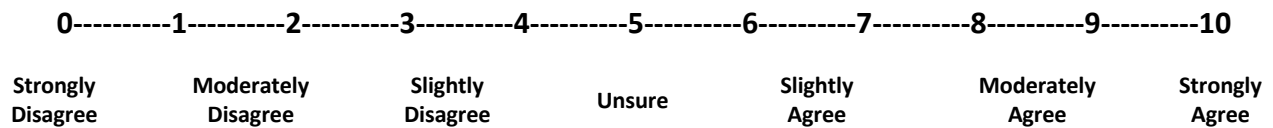
If 'YES' to any of the above, indicate the extent to which you agree or disagree at the present moment with the following statement by circling the appropriate number, keeping in mind your health related experiences.

1) My health related experiences are due to having diabetes.

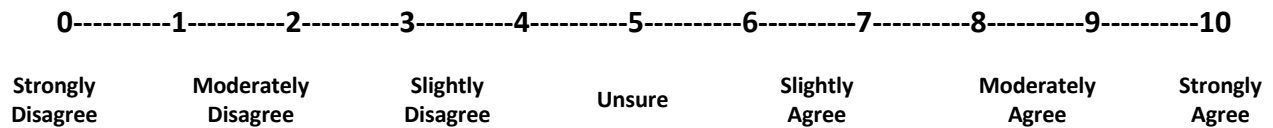


Please indicate the extent to which you agree or disagree at the present moment with each of the following statements by circling the appropriate number.

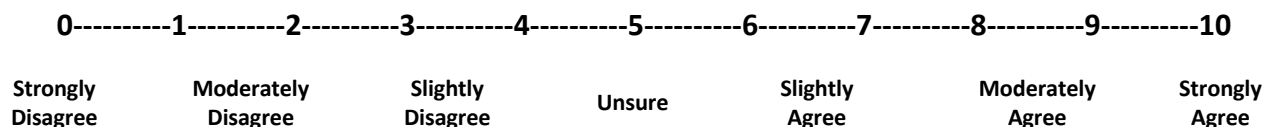
2) I have diabetes.



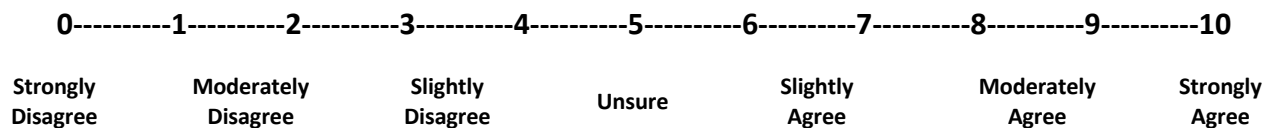
3) I NEED to make or maintain healthy life style changes to improve my diet and/or adjust the amount I exercise.



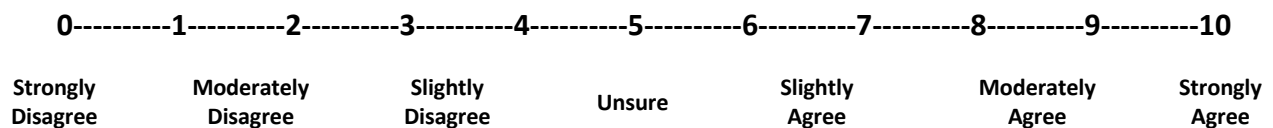
4) I have normal blood sugar/glucose levels.*



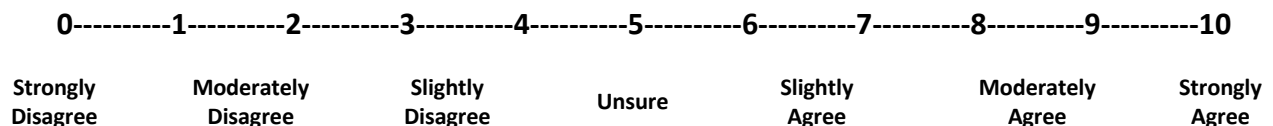
5) I can safely carry on my current lifestyle (i.e. eating/drinking and exercising as I currently do).*



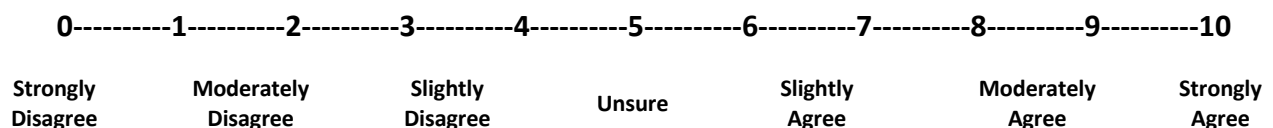
6) My diabetes has led or can lead to negative health consequences (e.g. heart disease, heart attack, stroke, near stroke, kidney disease, vision loss, numbness/tingling/loss of sensation in hands and feet, etc.).



7) My blood sugar/glucose levels are regularly in the diabetic range (i.e. fasting plasma glucose ≥ 126 mg/dl or ≥ 7.0 mmol/L or HbA1c $\geq 6.5\%$).*



8) I need blood sugar/glucose lowering treatment (i.e. insulin or medications).



THE END

*See scoring sheet for applicability