6) HEALTH SCREENING QUESTIONNAIRE

Personal Information

Name: | D.O.B: | Age:

Address:

Postcode:

Telephone No:

Gender: [X] Male [X] Female

Emergency Contact Name:

Relationship:

Telephone No:

Employment Status: Which of these activities best describes what you are doing at present?

- ☐ Permanently sick/disabled
- ☐ Retired Unemployed
- ☐ Employed (FT)
- ☐ Self Employed
- ☐ Employed (PT)
- ☐ Prefer not to say
- ☐ Full or Part time education

(If furloughed, select your usual state of employment).

Which one of the following best describes your ethnic group or background?

- ☐ White
- ☐ Asian/ Asian British
- ☐ Mixed/ Multiple ethnic groups
- ☐ Other ethnic group
- ☐ Black/ African/ Caribbean/ Black British
- ☐ Prefer not to say

Do you have a long-term illness, health problem or impairment that limits your daily activities?

☐ Yes ☐ No ☐ Prefer not to say

Do you require a carer?

☐ Yes; they will need to attend sessions with me (We may ask that your carer also completes a health screening form).

☐ Yes; they will need to help me mobilise in and out of the venue, but do not need to stay for the session.
☐ No

Do you have your own resistance band that you can bring to sessions? (N/A to all programmes)

☐ Yes ☐ No

Health Questions

1. Has your doctor ever said you have a heart condition and that you should only do physical activity recommended by a doctor?
   ☐ Yes ☐ No

2. Do you feel pain in your chest when you do physical activity?
   ☐ Yes ☐ No

3. In the past month, have you had a chest pain when you were not doing physical activity?
   ☐ Yes ☐ No

4. Do you lose balance because of dizziness or do you ever lose consciousness?
   ☐ Yes ☐ No

5. Do you have a bone or joint problem (for example back, knee or hip) that could be made worse by a change in your physical activity?
   ☐ Yes ☐ No

6. Is your doctor currently prescribing medication for your blood pressure or heart condition?
   ☐ Yes ☐ No

7. Are you currently pregnant or is there a possibility you might be?
   ☐ Yes ☐ No

8. Have you been doing any physical activity on a regular basis during the pandemic?
   ☐ None at all
   ☐ Some
   ☐ Yes, I have been regularly active

9. Have you recently recovered from a long term or serious illness?
   ☐ Yes ☐ No

Health Questions (COVID-19)

10. Have you had COVID-19?
    ☐ Yes ☐ No ☐ Don't know ☐ Prefer not to say

11. Have you had a COVID-19 vaccination?
    ☐ Yes Date of 1st vaccine…… Date of 2nd vaccine……..
    ☐ No
    ☐ Prefer not to say

12. **IF YOU SAID YES TO HAVING COVID-19…**
    Have you experienced what you consider to be any signs or symptoms of Long-COVID? E.g., fatigue, brain fog, shortness of breath, chest pain, insomnia

    ☐ Yes ☐ No ☐ Don't know ☐ Prefer not to say

13. If not, have you noticed any changes to your normal level of energy, physical activity or exercise that has been altered or seems to be worsened since your exposure to the virus?
    ☐ Yes ☐ No ☐ Don't know ☐ Prefer not to say

14. Had you been advised to shield during the COVID-19 pandemic?
    ☐ Yes ☐ No

    If yes, please comment

15. Have you any of the following health conditions or factors that put you at a high risk of getting seriously ill from COVID-19? Please provide details where applicable:
    - ☐ Age 70+
    - ☐ Heart disease/ failure
    - ☐ Diabetes
    - ☐ Respiratory condition
    - ☐ Neurological condition
    - ☐ Immunosuppressant medication
    - ☐ BMI 40+ (obesity)
    - ☐ Cancer
    - ☐ Organ transplant
    - ☐ Bone marrow or stem cell transplant in the last 6 months
    - ☐ Immune system suppressing health condition (MS, HIV etc)

16. Do you know of any reason why you should not take part in physical activity?
    ☐ Yes ☐ No
    If yes, please comment

Participant Declaration: I confirm that all the information I have provided is correct to the best of my knowledge, and that I must inform the Instructor should any of the information change. I understand that it is my own responsibility to provide and administer my own medication.

Sign: ……

Date: ……

Data Protection
To be filled in locally