Health Questionnaire 

# First name(s) ………………….................................

# Surname ………………….................................

**Date of Birth ………………………………………….**

**Home Address ………………………………………….**

**………………………………………….**

**Tel no ………………………………………….**

Please complete your health declaration fully. If you fail to declare significant information about your health, we may judge that you are not suitable to care for children and/or young people.

**1.**

|  |
| --- |
| Please give contact details of your doctors surgery and any hospitals you attend. |
|  |

**2.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you taking any medication? | **Yes** |  | **No** |  |
| If **YES**, what is it called, what is it for and what dose are you taking (see box or bottle label)? How long have you been taking it? | | | | |
|  | | | | |

**3.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you **receiving** any other treatment, like physiotherapy, counselling, acupuncture? | **Yes** |  | **No** |  |
| If **YES**, what and for how long? | | | | |
|  | | | | |

**4.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you waiting for any other treatment like those mentioned in **3**, or surgery? | **Yes** |  | **No** |  |
| If **YES**, please provide details. | | | | |
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**5.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you received any treatment, like those mentioned in question 3, in the **past 5 years**? | **Yes** |  | **No** |  |
| If **YES**, please provide details. | | | | |
|  | | | | |

**6.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you have any medical condition that: |  |  |  |  | If **Yes**, please provide details. |
| a) Affects your physical ability i.e. Stamina, walking, balance, bending, kneeling, lifting a child? | **Yes** |  | **No** |  |  |
| b) May impair your consciousness, make you black out, lose concentration or become confused or disoriented. | **Yes** |  | **No** |  |  |
| c) Affects your hearing in any way (after correction with any device)? | **Yes** |  | **No** |  |  |
| d) Affects your eyesight in any way (after any lens correction)? | **Yes** |  | **No** |  |  |
| e) Causes depression, anxiety, panic attacks, mood swings, anger etc? | **Yes** |  | **No** |  |  |
| f) Causes severe pain? | **Yes** |  | **No** |  |  |
| g) Causes excessive drowsiness? | **Yes** |  | **No** |  |  |
| h) Affects you in any other way? | **Yes** |  | **No** |  |  |

**7.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you been investigated or treated for any of the above, in the past five years? | **Yes** |  | **No** |  |
| If **YES**, what is it called, what is it for and what dose are you taking (see box or bottle label)? How long have you been taking it? | | | | |
|  | | | | |

**8.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In the **past five years** have you had **any** medical problems other than minor illness such as colds? | | **Yes** |  | **No** |  |
| If **YES**, please provide details. | | | | | |
| Date | Details | | | | |
|  | | | | | |

**9.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| In the **past five years** have any hospital admissions or outpatient treatment? | | **Yes** |  | **No** |  |
| If **YES**, please provide details. | | | | | |
| Date | Details | | | | |
|  |  | | | | |

**10.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Are you suffering from or have you ever suffered from any of the following? Please indicate with an asterisk (\*) any conditions that are still current. | | | | | | |
| a) Depression, anxiety, stress-related illness or other mental health problems, including self-harm and eating disorders | | **Yes** | |  | **No** |  |
| b) Blackouts, fits, epilepsy or faints | | **Yes** | |  | **No** |  |
| c) Heart Problems | | **Yes** | |  | **No** |  |
| d) Diabetes | | **Yes** | |  | **No** |  |
| e) Breathing difficulties such as asthma | | **Yes** | |  | **No** |  |
| f) Problems with back, neck, arms, legs or joints | | **Yes** | |  | **No** |  |
| g) Alcohol or drug dependency or misuse | | **Yes** | |  | **No** |  |
| If you have answered **YES** to any of the above conditions, please provide details of any date(s) you received treatment and the length of time you were on sick leave. | | | | | | |
| Date | Treatment | | Time on Sick Leave | | | |
| a) |  | |  | | | |
| b) |  | |  | | | |
| c) |  | |  | | | |
| d) |  | |  | | | |
| e) |  | |  | | | |
| f) |  | |  | | | |
| g) |  | |  | | | |

**11.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Have you ever suffered from or been in contact with a significant infectious disease such as tuberculosis or hepatitis? | | **Yes** |  | **No** |  |
| If **YES**, please provide details. | | | | | |
| Date | Details | | | | |
|  |  | | | | |
|  |  | | | | |
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|  |  | | | | |

**I certify that the above statements are true**

Signed: ……………………………………………………. Date: ……………………..