[](http://www.ageuk.org.uk/redbridgebarkinghavering/)

**Level One Risk Assessment and Pre Exercise Health Questionnaire**

Venue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class: \_\_\_\_\_\_\_\_\_\_\_\_\_Client Charity Log No:\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | Male | | | | | Female | |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tel No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | |
| Please circle: | | | | Live Alone | | | | | Sheltered Housing | | | | | | | | Rented | | | | | | Home owner | | | | | | | | | | |
| Religion: | | | | | | | | | Ethnicity: | | | | | | | | | | | | | | Disabled? | | | | | YES / NO | | | | | |
| Name and address of person to contact in an emergency: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tel No: | | | Day time | | | | | | | | | | | Evening | | | | | | | | | | | | | | | | | | | |
| Name and address of GP: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tel No: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medical conditions: | | | | | Parkinson’s | | | | | | | | Diabetes | | | | | | | | | Stroke | | | | | | | | Dementia | | | |
| Other conditions please specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medications: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you had any chest pain in the last year?  Comments: | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | | |
| Do you get pain in the calf when walking?  Comments: | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | | |
| Do you get short of breath when walking with people of your own age (on level ground)? YES / NO  Comments: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you have any problems getting up from a chair? | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | | |
| Any experience of confusion problems? | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | | |
| Do you have asthma?  Comments | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | | |
| Do you suffer from arthritis or any aches and pains in the joints?  Comments: | | | | | | | | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | |
| Are you liable to faint or have dizzy spells?  Comments: | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | |
| Do you have any eyesight problems? | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | |
| Do you have any problems with your hearing?  Comments: | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | |
| Do you have problems with your balance?  Comments: | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | |
| Do you have problems with your feet? | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | |
| Do you use a walking aid? | | | | | | | | | YES / NO | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please specify: | | | | | Walking Stick | | | | | | | | | | Walking Frame | | | | | | | | | | | Wheelchair | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you doing any other type of exercise programme? | | | | | | | | | | | | | | | | | | YES / NO | | | | | | | If yes, please give details: | | | | | | |
| Any other health problems or reasons why your ability to take part in exercise might be affected? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Falls Problem Identification** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you had a fall in the last year? | | | | | | | | | | YES / NO | | | | | | | If yes, how many falls: \_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Did you require medical intervention? | | | | | | | | | | YES / NO | | | | | | | If yes, please tick below: | | | | | | | | | | | | | | |
| GP | Ambulance | | | | | A&E | | | | | Hospital Admission | | | | | | | | | | | | | | Length of hospital  admission (in days): \_\_\_\_\_\_\_ | | | | | | |
| Were you able to summon help? | | | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | |
| Are you able to do the things you used to prior to the fall? | | | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | |
| Have you attended a Falls Clinic? | | | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | |
| Is your mobility getting worse? | | | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | |
| Do you have an emergency alarm (pendant)? | | | | | | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | |
| Have you broken any bones as the result of a fall? (ie from standing height) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES / NO | |
| Is there a family history of osteoporosis? (e.g. hip fracture) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES / NO | |
| Have you ever been prescribed systemic steroids for longer than 3 months? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES / NO | |
| **Blood Pressure** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you had your blood pressure checked in the last year? | | | | | | | | | | | | | | | | | | | | | | | | YES / NO | | | | | | | |
| Do you suffer from either: | | | | | | | High Blood Pressure | | | | | | | | | | | | | Low Blood Pressure | | | | | | | | | | | |
| Are you on 4 or more medications? | | | | | | | | | | | | | | YES / NO | | | | | | | | | | | | | | | | | |
| Have you had a review of your medications by your GP in the last year? | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES / NO | | | |
| Are you a carer for someone? YES/NO | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |

**Where did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In order to help you, we need to store information about you. The law says that we must get your consent to do this. Everything you tell us will be treated confidentially and your data will be subject to the data protection legislation and General Data Protection Regulations. Records will be kept securely for 6 years and** **then securely destroyed. You can withdraw consent and request access to your records at any time.**

1. **I consent to Age UK Redbridge, Barking & Havering recording personal information**

**about me: YES / NO Verbal Consent Given: YES / NO**

Because we may need to speak to other people in order to help you, we need to ask for your consent to speak on your behalf.

1. **I consent to Age UK Redbridge, Barking & Havering corresponding on my behalf with**

**the following third parties: YES / NO Verbal Consent Given: YES / NO**

|  |  |
| --- | --- |
| **Third Party** | **YES / NO** |
| 1. **Next of Kin** |  |
| 1. **GP** |  |
| 1. **NHS Falls Services** |  |
|  |  |
|  |  |
|  |  |

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

Please send to the Falls Prevention Coordinator,

Age UK Redbridge, Barking and Havering, 103 Cranbrook Road, Ilford IG1 4PU

Or Email to:

**glenda.templeman@ageukrbh.org.uk**

or **admin@ageukrbh.org.uk** Tel: 0208 220 6000