West Yorkshire
Critical Care & Major Trauma
Operational Delivery Networks

Health Questionnaire

Under each heading, please tick the ONE box that best describes your health **TODAY.**

MOBILITY

I have no problems in walking about □
I have slight problems in walking about □
I have moderate problems in walking about □
I have severe problems in walking about □
I am unable to walk about □

SELF-CARE

I have no problems washing or dressing myself □
I have slight problems washing or dressing myself □
I have moderate problems washing or dressing myself □
I have severe problems washing or dressing myself □
I am unable to wash or dress myself □

USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)*

I have no problems doing my usual activities □
I have slight problems doing my usual activities □
I have moderate problems doing my usual activities □
I have severe problems doing my usual activities □
I am unable to do my usual activities □

PAIN / DISCOMFORT

I have no pain or discomfort □
I have slight pain or discomfort □
I have moderate pain or discomfort □
I have severe pain or discomfort □
I have extreme pain or discomfort □

ANXIETY / DEPRESSION

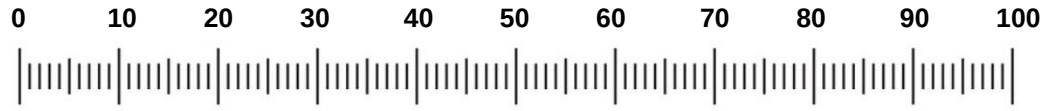
I am not anxious or depressed □
I am slightly anxious or depressed □
I am moderately anxious or depressed □
I am severely anxious or depressed □
I am extremely anxious or depressed □

We would like to know how good or bad your health is TODAY.

This scale is numbered from 0 to 100.

- 100 means the best health you can imagine.
- 0 means the worst health you can imagine.

Mark an X on the scale to indicate how your health is TODAY.



Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = ☐

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Trauma Screening Questionnaire

Trauma Screening Questionnaire

Your Own Reactions Now to the Traumatic Event

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened a few weeks ago. Please indicate whether or not you have experienced any of the following AT LEAST TWICE IN THE PAST WEEK:

	YES, AT LEAST TWICE IN THE PAST WEEK	NO
1. Upsetting thoughts or memories about the event that have come into your mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		
4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Being jumpy or being startled at something unexpected		

Name:

Date completed: