

20. How long have you had your health problem?
please tick one

Under 6 months
 Under 1 year
 Under 5 years
 5 years or longer

21. Have you spent time in hospital or residential care in the last 3 years?

No
 Yes - *please give details below*

Name of the hospital	What treatment are you having?	Dates you were in hospital or residential care
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

22. Are you attending day hospital, or have clinic appointments because of your health problem?

No
 Yes - *please give details below*

Name of the hospital or clinic	What treatment are you having?	How often do you attend? How long is each visit?
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

23. Does anyone help you at home because of your health problem
for example, to wash and dress?

No
 Yes - *please give details below*

Who helps you?

What help or service do they provide for you?

24. Do you have difficulty using a lift?

No
 Yes - *please give a reason why and detail any treatment you have had for your problem*

25. Do you have difficulty getting on and off a bus by your self?

No
 Yes - *please say why it is difficult for you to get on and off a bus*

26. Do you have difficulty walking up a flight of steps - e.g. you are in severe pain or severely out of breath? (A flight of steps is usually 12-14 stairs).

No - please go to page 28

Yes - please write in the number of steps you can manage without being in severe pain or severely out of breath

27. How far can you walk by your self on level ground? please tick ONE

I cannot walk

no more than 30 yards or metres

I can take a few steps only

no more than 100 yards or metres

I can walk independently

28. Do you use any of the following? please tick all the ones that you use

walking stick

wheelchair outdoors only

walking frame

wheelchair indoors only

crutches

wheelchair all the time

none

29. Do you have any equipment or adaptations in your home that you use to help you because of your health problem?

No

Yes - please give details of your equipment or adaptation

30. What is your usual occupation? Include work done in the home

Is your health problem currently preventing you from doing your usual occupation?

No

Yes - please give details

31. Do you get any of these state benefits? please tick all the ones you get

Disability Living Allowance - mobility component

please tick rate **Lower rate** **Higher rate**

Disability Living Allowance - care component

please tick **Lower rate** **Middle rate** **Higher rate**

Attendance Allowance

Disabled Persons Tax Credit

Incapacity Benefit

Job Seekers Allowance

Severe Disablement Allowance

Pension

War Disablement Pension

Other benefit - please write in

32. Additional information Please write in anything else you would like to tell us about your health problems and how they affect you

Please Confirm your Weight Height

33. Declaration I declare that the information in this form is true and complete

	Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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Your Signature (or your parent/guardians signature)
Please Sign and Date

34. I agree that that my doctor, consultant or any other health or social care professional involved in my care can be contacted and asked to provide information about my health needs. *please tick*

35. Please give the full name and address of your general practitioner (family doctor)

Their name:

Phone Number

36. Please give the full name and address of a health or social care professional who can provide information about your health needs

Phone Number

37. If someone else has helped you complete this form, please ask them to give us their contact details.

Their name:
Their relationship to you:

The council may telephone this person where a second point of contact is needed for you

Phone Number

Please note that your doctor will not necessarily be contacted. You must give full and complete details of your health problem on this form.