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| **HEALTH TRAINERS CLIENT REGISTRATION FORM**  |
| **1. CLIENT DETAILS** |
| First name: | Last name: |
| Address: | Home Tel: |
|  | Mobile: |
| Postcode: | Email: |
| Gender: Male **€** Female **€** Other **€** | D.O.B:  |
| **2. ETHNIC GROUP** |
| A: White – British **€**  | B: White – Irish  | **€** | C: Other White Background | **€** | D: Mixed – White and Black Caribbean | **€** | E: Mixed – White and Black African | **€** |
| F: Mixed – White and Asian **€** | G: Mixed – Any Other Mixed Background | **€** | H: Asian or Asian British – Indian  | **€** | I: Asian or Asian British – Pakistani  | **€** | J: Asian or Asian British – Bangladeshi  | **€** |
| K: Any Other Asian Background **€** | L: Black or Black British – Caribbean  | **€** | M: Black or Black British – African | **€** | N: Any Other Black Background | **€** | O: Chinese | **€** |
| P: Any Other Ethnic Group **€** | Z: Not Stated | **€** |  |  |  |  |  |  |
| **3. DISABILITY STATUS** |
| Under the Equality Act 2010 a person has a disability if they have a physical or mental impairment which has a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.**Does the client consider themselves to have a disability?** YES € NO € Does not wish to disclose  |

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| Please state the type of impairment that applies to you. People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply, please mark ‘Other’ and specify:: |

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| Physical Impairment  | **€** | Sensory Impairment  | **€** | Mental Health Condition  | **€** | Learning Disability/Difficulty  | **€** |
| Long-standing illness  | **€** | Do not wish to disclose  | **€** | Other (Please specify): | **€** |

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| **4. MEDICAL CONDITIONS** |
| Do you have any medical conditions? YES  NO  Does not wish to disclose **Details:** |

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| **5. MENTAL HEALTH AND EMOTIONAL WELL BEING** |
| Would you be interested in taking part in a specialist Health Trainers programme for people who have experienced mental health or emotional difficulties such as anxiety, low mood, stress or similar issues? | **YES €** |
|  **NO €** |
| **6. EMPLOYMENT STATUS** |
| Employed full-time **€**   | Employed part-time | **€** | Full-time carer | **€** | Looking after home or family full-time | **€** | Permanently sick/disabled | **€** |
| Retired **€**  | Self-employed | **€** | Student | **€** | Unemployed | **€** | Volunteer | **€** |
| Other **€**  | Response declined | **€** |  |  |  |  |  |  |
| **7. GP DETAILS** |
| GP Registered € Unregistered € | GP Name: | Practice Name: |
| Practice Address: | Postcode: |
| Telephone: | Fax:  | Client NHS Number:  |
| **8. HOW HEARD ABOUT SERVICE?** |
| Local media **€**  | Poster/leaflet | **€** | Health Trainer outreach | **€** | Health Champion outreach | **€** | Health Trainer activity | **€** |
| Word of mouth **€**  | Referral – GP/Primary Care | **€** | Referral – BLT/CHS | **€** | Referral – CMHT/ELFT | **€** | Referral – LinkAge+ | **€** |
| Referral – **€** Children’s Centre  | Referral - Other | **€** | Other  | **€** |  |  |  |  |

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| **9. CLIENT’S SUPPORT NEEDS** |  |
| Healthy Eating | **€** | Physical Activity **€**  | Weight Loss **€**  | Smoking Cessation **€** |
| Alcohol  | **€** | Financial Inclusion  **€**  | Employment support **€** | Welfare/benefits advice **€**  |
| Fuel poverty  | **€** | Education/Training **€**  | Social support **€**  | Advocacy & legal advice **€**  |
| Volunteering/Timebank |  **€** | Other (please describe)  |  |
| **10. SMOKING BRIEF INTERVENTION** |
| Current smoker: Yes € No € User of smokeless tobacco Yes € No € Brief Intervention Delivered Yes € No € |
| Interested in receiving support to give up smoking/tobacco use Yes € No € |
| **REFERRAL FOR SMOKING CESSATION SUPPORT** | Pharmacist | **€** | GP  | **€** | Pregnancy & Early Years Service | **€** |
| Bangladeshi Stop Tobacco Project **€**  | Specialist Smoking Cessation Service | **€** | Health Trainer 1:1 support | **€** | Health Trainer group support | **€** | Referral not wanted at this time | **€** |
| **11. OUTCOME OF INITIAL ASSESSMENT** |
| Eligible – proceed to assessment | **€** | Eligible – did not want to proceed **€** | Eligible – service not wanted at this stage **€** |
| Signpost only  | **€** | Information only  **€** | Recommended to primary care  **€** |
| Not eligible  | **€** | Referral to accredited Health Trainer (for Health Champion use only) **€** | Could not make contact with client  **€** |
| Referred to wider services **€** Details: |
| **12. CONSENT** |
| I understand the reasons for collecting and holding personal information on the Health Trainers Service database. I have agreed with my Health Trainer that they can contact me again to follow-up on my progress.  |
| Client signature: |  | HT signature: |  | Date: | \_\_\_/\_\_\_/\_\_\_ |

**Additional Notes:**

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