SSCH - Menopause Awareness - Pre Session Form

* Indicates required question

1. Session Date *

Example: January 7, 2019

2. First Name *

3. Last Name *

4. Gender *

Mark only one oval.

- Male
- Female
- Non-binary
- Other
- Prefer not to say

5. Your Email *

6. Your Employer *

7. Occupation *

Mark only one oval.

- Carer
- Nurse
- Manager
- Domestic & Housekeeping
- Kitchen & Catering
- Maintenance
- Activities
- Other
- I am not working in care

8. Age *

Check all that apply.

- 16-18
- 19-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65-74
- 75-84
- 85 +
- Prefer not to say

9. Ethnicity *

Mark only one oval.

- White
- Asian or Asian British
- Black or Black British
- Other ethnic group
- Mixed / multiple heritage
- Prefer not to say

10. Do you consider yourself a disabled person? *

Mark only one oval.

- No
- Prefer not to say
- Communication (e.g. impaired speech)
- Hearing (e.g. mild to profound deafness)
- Learning (mind to profound learning disability)
- Mental ill health (bipolar disorders, schizophrenia, depression, anxiety)
- Visual (e.g. partially sighted to blind)
- Developmental (e.g. dyslexia)
- Impaired memory/concentration or ability to understand (e.g. head injury, stroke, dementia)
- Long-term illness or health condition (e.g. cancer, HIV, diabetes, chronic heart disease, arthritis, chronic asthma)
- Mobility or physical (e.g.dexterity)
- Autistic Spectrum Disorders or Attention Deficit Disorders

11. Are you experiencing any of the following symptoms? *

Mark only one oval.

- ◯ Changes to your period (i.e. irregular or heavy periods)
- ◯ Changes to your mood (i.e. low mood, anxiety, mood swings and low self-esteem)
- ◯ Problems with memory or concentration (brain fog)
- ◯ Hot flushes (sudden feelings of hot or cold in your face, neck and chest which can make you dizzy)
- ◯ Difficulty sleeping
- ◯ Palpitations (when your heartbeats suddenly become more noticeable)
- ◯ Headaches and migraines that are worse than usual
- ◯ Muscle aches and joint pains
- ◯ Changed body shape and weight gain
- ◯ Skin changes including dry and itchy skin
- ◯ Reduced sex drive
- ◯ Vaginal dryness and pain, itching or discomfort during sex
- ◯ Recurrent urinary tract infections (UTIs)
- ◯ Sensitive teeth, painful gums or other mouth problems
- ◯ None symptoms
- ◯ Prefer not to say

12. Which statement reflects your sleep patterns? *

Mark only one oval.

- ◯ I sleep well most nights.
- ◯ I don't sleep well most days (can't fall asleep/wake up often/restless/don't feel refreshed).

13. How many hours do you sleep each night on an average? *

Mark only one oval.

- ◯ Less than 5 hours
- ◯ 5 - 6 hours
- ◯ 7 - 8 hours
- ◯ 8 - 9 hours
- ◯ More than 9 hours

14. How often do you exercise a week? *

Mark only one oval.

- ◯ I don't exercise.
- ◯ Once a week
- ◯ 2 or 3 times
- ◯ 4 or 5 times
- ◯ More than 5 times

15. What exercise do you do and how long? *

16. How would you rate your diet? *

Mark only one oval.

	1	2	3	4	5	
I eat well	◯	◯	◯	◯	◯	I don't have a good diet and need some help getting back on track.

17. Is there anything in particular you need support with? *

18. Anything else you would like to share that may be relevant to our session? *