

PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY

**IF YOU TAKE PRESCRIPTION MEDICATION PLEASE ENSURE YOU
HAVE ENOUGH TO LAST UNTIL WE ARE ABLE TO PROCESS YOUR
REGISTRATION**

Name *	Address *	Telephone No *
Date of Birth		E-mail:
		Emergency Contact No

Height *	Weight *	Allergies

*	How many per Week	Tetanus
Smoker	() Cigarettes ()	(date of last booster if known)
Ex-Smoker	() Cigars ()	
Year Stopped	() Pipe ()	
Non-Smoker	() Roll Ups ()	

Average Alcohol intake in Units Per Week (see reverse for unit chart)

Do you suffer from (please tick)	Family History of Heart Disease: Yes / No Relationship	Current Medication
Asthma () Angina ()	Family History of Stroke: Yes / No Relationship	
High B/P () Epilepsy ()		
Mental Illness () Diabetes ()		
Hypothyroidism () Heart Attack ()		
Hyperthyroidism () COPD ()		
Atrial Fibrillation () Stroke ()		
Heart Disease ()		

DO YOU HAVE A CARER OR ARE YOU A CARER Yes / No
If <u>Yes</u> Please ask for a carer's registration form

Please tick the box below that most accurately describes you national identity and ethnic origin
This information will be treated in the strictest confidence

*	Please Tick		Please Tick
British or Mixed British		Pakistani or British Pakistani	
Irish		Bangladeshi or British Bangladeshi	
Other White Background		Other Asian Background	
White & Black Caribbean		Caribbean	
White & Black African		African	
White & Asian		Other Black Background	
Other Mixed Background		Chinese	
Indian or British Indian		Other Ethnic Category (Please State)	

FIRST LANGUAGE *	
DO YOU NEED AN INTERPRETER	YES / NO

ALCOHOL USERS DISORDERS IDENTIFICATION TEST (AUDIT C)

Name: Date of birth

QUESTIONS	0	1	2	3	4	YOUR SCORE
How often do you have a drink that contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring: A total of 5+ could indicate hazardous or harmful drinking.

It is recommended that you complete a full alcohol AUDIT (see below) when scoring 5 or above.

ALCOHOL USERS DISORDERS IDENTIFICATION TEST (AUDIT)

Name: Date of birth

QUESTIONS	0	1	2	3	4	YOUR SCORE
How often do you have a drink than contains alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week	
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in last year		Yes, during last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in last year		Yes, during last year	

Total

Scoring: 0-7 sensible drinking, 8-15 hazardous drinking, 16-19 harmful drinking and 20+ possible dependence
