



NHS Lothian MANUAL HANDLING DEPARTMENT Manual Handling Health Questionnaire

Confidential

Name Date of Birth

Course Attended Patient Handling Induction Non Patient Induction
 Non Patient Handling Update Patient Handling Update

Course Date: / /

Referral: Have you been referred by Occupational Health or by a physiotherapist for this course? Yes No

Area of Work

Nursing – Registered Nursing - CSW AHP
 A & C Support Services Other, please specify _____

Please complete the following:

Medical Condition/Complaint	At present I have this complaint		Previously I have had this complaint		Amount of time off work due to condition/complaint	Was this caused by work?
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Neck pain/discomfort	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Shoulder/Arm pain/discomfort	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Back pain/discomfort	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Knee pain/discomfort	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>		

Within the last year have you:

Been pregnant	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Had an abdominal operation	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Do you have any other disorder, which may affect your ability to participate in the practical manual handling session? **YES** **NO**
If yes, please specify below:

I am happy to do the practical session of the course and will advise a member of the manual handling team if I feel any discomfort.

Signature:

For office use

Please detail any further necessary information sought and advice given.

Tutor Signature:

Designation:

Date: