**Preliminary health check form**

|  |  |
| --- | --- |
| **Surname** |  |
| **First name** |  |
| **Date of birth** |  |
| **D number** |  |
| **Pregnant** | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Acute illness**  Do you currently have any symptoms or ailments?  (For example: fever, cough, difficulty breathing, diarrhoea, pain, toothache, etc.) | Yes | No |
| **Chronic illness**  Do you have any chronic diseases?  (For example: heart or lung disease, cancer, diabetes, metabolic disorder, infectious disease, mental illness, etc.) | Yes | No |
| **Medications**  Is there any medicine that you take on a regular basis that you need now? | Yes | No |
| **Disability**  Do you have a disability for which you need follow-up or assistive devices? | Yes | No |
| **Mental health symptoms**  Over the past couple of weeks, have you felt down, depressed or hopeless?  If so,to what extent does this affect you in your every-day activities? (check the relevant box)  To a small extent  To a moderate extent  To a large extent  *Assess the need to complete a separate form on mental health symptoms and traumatic experiences* | Yes | No |

**Vaccinations. Check the relevant box if any of the following vaccinations are needed:**

MMR vaccine

COVID-19 vaccine

Form completed (date): .......................................

**Preliminary health check form –**

**Mental health symptoms and traumatic experiences**

|  |  |
| --- | --- |
| **Surname** |  |
| **First name** |  |
| **Date of birth** |  |
| **D number** |  |

*This form should not be used for everyone. It must be assessed in each individual case – on the basis of information that has emerged about the person’s background and history, migration process, previous traumas and mental health symptoms – whether it is necessary to carry out a further assessment as outlined below.*

*The main goal is to chart the patient’s current life situation and whether they have someone they can talk to about any problems and concerns, or strong emotional reactions. The purpose is to identify any past traumatic experiences that may lead to mental health symptoms with a risk that indicates a need for immediate health care, and ensure that the individual receives good follow-up. It is voluntary to respond, and the patient does not have to provide details if they do not want to.*

* In the conversation, describe common reactions after traumatic events
* Identify the need for urgent mental health care
* Explain that this is only a general check to identify any immediate follow-up needs

Form completed (date): .......................................

|  |  |  |
| --- | --- | --- |
|  | YES | NO |
| Have you ever had to leave your home to live in hiding or under cover? |  |  |
| Have you ever been in mortal danger? |  |  |
| Have you ever been a victim of psychological, physical or sexual abuse? |  |  |
| Have you ever seen someone killed or seriously injured? |  |  |
| Do you have anxiety that strongly affects your every-day life? |  |  |
| Have you ever seen someone be tortured or subjected to psychological, physical or sexual abuse? |  |  |
| Do you have recurring thoughts or images that are difficult to get out of your head? |  |  |
| Do you have problems falling or staying asleep? Nightmares? |  |  |
| Have you been subjected to torture or inhuman treatment?   (If YES, inform the interviewee that they can be referred for further help) |  |  |
| Do you need to talk to someone about this? (If YES, inform the interviewee that they will be referred for further help) |  |  |