SPFL TRUST Scottish Football SUPPORTING COMMUNITIES | The Football Pools

FOOTBALL FANS IN TRAINING

MEN'S FITNESS AND HEALTHY LIVING PROGRAMME

SELF COMPLETE QUESTIONNAIRE

BARCODE

FFIT FOLLOW UP 2015

Researchers from the Universities of Glasgow, Edinburgh and Dundee, and the Medical Research Council are working with the SPFL Trust to evaluate the long term impact following participation in Football Fans in Training.

First, some questions about Football Fans in Training (FFIT) and what you have been doing since we last saw you.

1 Which FFIT programme(s) did you attend?

Please tick ALL boxes that apply

I have never attended a FFIT programme	☐ 1	If ticked, please go to **Q 6**
I attended FFIT from Aug/Sept to Nov/Dec **2011**	☐ 2	
I attended FFIT from Aug/Sept to Nov/Dec **2012**	☐ 3	
I attended FFIT at another time(s)	☐ 4	If ticked, pleases give dates below ↓

_____

_____

_____

2 At the end of the sessions in the club (after the 12 week programme) how much weight did you lose?

(If you have attended more than one FFIT programme, please answer in relation to the first FFIT programme that you attended)

Please tick ONE box

I attended FFIT but did not lose any weight during the 12 week programme	☐ 1
I lost up to 5% of my baseline weight during the 12 week programme	☐ 2
I lost 5 – 10% of my baseline weight during the 12 week programme	☐ 3
I lost more than 10% of my baseline weight during the 12 week programme	☐ 4

If you can, please tell us roughly how much you lost during the 12 week FFIT programme in either: _____stones_____pounds or in _____kilograms

3 Have much of each of the following have you done since you completed the FFIT programme?

(If you have attended more than one FFIT programme, please answer in relation to the first FFIT programme that you attended.)

	Please tick ONE box on EACH line	Very Frequently	Frequently	Occasionally	Rarely	Never
a	Been in contact with other men who have taken part in FFIT at your club?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b	Been in contact with the coaches who deliver/have delivered FFIT at your club?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c	Attended any other health or fitness programmes or groups at your club?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d	Attended a health or fitness programme or group somewhere else?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e	Attended a weight-reduction clinic at your GP surgery or another NHS setting?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f	Attended a commercial weight management group like Weight Watchers	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **LAST 7 DAYS**. Please think about the activities you do at work, as part of your house and garden work, to get from place to place, and in your spare time for recreation, exercise or sport.

Please answer each question even if you do not consider yourself to be an active person.

Please think about the activities you do as part of everyday life and only those you did for at least 10 minutes at one time.

6a **During the LAST 7 DAYS, on how many days did you do VIGOROUS physical activities like heavy lifting, digging, aerobics or fast bicycling?**

Think only of activities that you did for at least 10 minutes at one time and that took hard physical effort and made you breathe much harder than normal.
Write in days per week or tick if none.

_____ **days per week**
also complete 6b

or **none** ☐
go to Question 7a

6b **How much time in total did you usually spend on one of those days doing VIGOROUS physical activities?**

Write in hours and minutes EACH day or tick if don't know/not sure.

_____ **hours** ____ **minutes**

or **don't know/ not sure** ☐

7a **During the LAST 7 DAYS, on how many days did you do MODERATE physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.**

Think only of activities that you did for at least 10 minutes at one time and that took moderate physical effort and made you breathe somewhat harder than normal.
Write in days per week or tick if none.

_____ **days per week**
also complete 7b

or **none** ☐
go to Question 8a

7b **How much time in total did you usually spend on one of those days doing MODERATE physical activities?**

Write in hours and minutes EACH day or tick if don't know/not sure.

_____ **hours** ____ **minutes**

or **don't know/ not sure** ☐

8a **During the LAST 7 DAYS, on how many days did you walk for at least 10 minutes at a time?**

This includes walking at work and at home, walking to travel from place to place, and any other walking that you did solely for recreation, sport, exercise or leisure.

Write in days per week or tick if none.

_____ **days per week**
also complete 8b

or **none** ☐
go to Question 9

8b **How much time in total did you usually spend walking on ONE of those days?**

Write in hours and minutes for ONE of those DAYS or tick if don't know/not sure.

_____ **hours** ____ **minutes**

or **don't know/ not sure** ☐

The next question is about the time you spent sitting on weekdays while at work, at home, while doing course work and during leisure time.

This includes time spent sitting at a desk, visiting friends, reading, travelling on a bus or sitting or lying down to watch television.

9 **During the LAST 7 DAYS, how much time in total did you usually spend sitting on a week day?**

Write in hours & minutes ON ONE OF THOSE DAYS or tick if don't know/not sure.

_____ **hours** ____ **minutes**

or **don't know/ not sure** ☐

10 **Comparing yourself with most people your age, would you rate your level of fitness as…**

Please tick ONE box

Very good	Good	Moderate	Poor	Very poor
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

11 **Please tick one box on each line below to show whether you strongly agree, agree, disagree or strongly disagree with each statement.…**

	Please tick ONE box on EACH LINE	Strongly Agree	Agree	Disagree	Strongly Disagree
1	On the whole, I am satisfied with myself.	☐ 1	☐ 2	☐ 3	☐ 4
2	At times, I think I am no good at all.	☐ 1	☐ 2	☐ 3	☐ 4
3	I feel that I have a number of good qualities.	☐ 1	☐ 2	☐ 3	☐ 4
4	I am able to do things as well as most other people.	☐ 1	☐ 2	☐ 3	☐ 4
5	I feel I do not have much to be proud of.	☐ 1	☐ 2	☐ 3	☐ 4
6	I certainly feel useless at times.	☐ 1	☐ 2	☐ 3	☐ 4
7	I feel that I'm a person of worth, at least on an equal plane with others.	☐ 1	☐ 2	☐ 3	☐ 4
8	I wish I could have more respect for myself.	☐ 1	☐ 2	☐ 3	☐ 4
9	All in all, I am inclined to feel that I am a failure.	☐ 1	☐ 2	☐ 3	☐ 4
10	I take a positive attitude toward myself.	☐ 1	☐ 2	☐ 3	☐ 4

12 **In general, would you say your health is:**

Please tick ONE box

Excellent	Very good	Good	Fair	Poor
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

The following questions are about **ACTIVITIES** you might do during a typical day.

13 **Does <u>YOUR HEALTH NOW LIMIT YOU</u> in these activities? If so, how much?**

	Please tick ONE box on EACH line	Yes, limited a lot	Yes, limited a little	No, not limited at all
a	**MODERATE ACTIVITIES** *such as moving a table, pushing a vacuum cleaner, bowling, or playing golf:*	☐ 1	☐ 2	☐ 3
b	**Climbing SEVERAL flights of stairs:**	☐ 1	☐ 2	☐ 3

14 **During the PAST 4 WEEKS how much of the time have you had any of the following problems with your work or other regular daily activities AS A RESULT OF YOUR PHYSICAL HEALTH?**

	Please tick ONE box on EACH line	all of the time	most of the time	some of the time	a little of the time	none of the time
a	ACCOMPLISHED LESS than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b	Were limited in the KIND of work or other activities	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

15 **During the PAST 4 WEEKS, how much of the time have you had any of the following problems with your work or other regular daily activities AS A RESULT OF ANY EMOTIONAL PROBLEMS (such as feeling depressed or anxious)?**

	Please tick ONE box on EACH line	all of the time	most of the time	some of the time	a little of the time	none of the time
a	ACCOMPLISHED LESS than you would like	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b	Did work or activities LESS CAREFULLY than usual	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

16 **During the PAST 4 WEEKS, how much did PAIN interfere with your normal work** *(including both work outside the home and housework)***?**

Please tick ONE box on EACH line

Not at all	A little bit	Moderately	Quite a bit	Extremely
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

The next questions are about how you feel and how things have been with you during the PAST 4 WEEKS. For each question, please tick the one answer that comes closest to the way you have been feeling.

17 **How much of the time during the PAST 4 WEEKS…**

Please tick ONE box on EACH line

		all of the time	most of the time	some of the time	a little of the time	none of the time
a	Have you felt calm and peaceful?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b	Did you have a lot of energy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c	Have you felt downhearted and depressed?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

18 **During the PAST 4 WEEKS, how much of the time have your PHYSICAL HEALTH or EMOTIONAL PROBLEMS interfered with your social activities (like visiting friends, relatives, etc.)?**

Please tick ONE box

all of the time	most of the time	some of the time	a little of the time	none of the time
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

19 **Now, thinking about yourself and how you normally feel, to what extent do you generally feel…**

Please tick ONE box on EACH line

	Not at all	A little	Moderately	Quite a bit	Extremely
Upset	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Hostile	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Alert	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Ashamed	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Inspired	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Nervous	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Determined	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Attentive	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Afraid	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Active	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

20 Please look at the list of NHS Services below

Please tick NO or YES. If you tick 'yes' for any of the services, please give the number of times you have used the service in the LAST 3 MONTHS.

The example shows: two visits to the Dentist in last 3 months

Over the LAST 3 MONTHS, have you used any of the following NHS Services?

Example: *Dentist*		No ☐ 2	Yes ☑ 1	→ 2
Please tick ONE box on EACH LINE				Number of visits
	Your GP or another GP	No ☐ 2	Yes ☐ 1	→
	Nurse	No ☐ 2	Yes ☐ 1	→
	Physiotherapist - outpatient	No ☐ 2	Yes ☐ 1	→
	Doctor or nurse in an emergency department *(Casualty / A&E)*	No ☐ 2	Yes ☐ 1	→
	Outpatient appointments	No ☐ 2	Yes ☐ 1	→ If yes, provide details @ 21
	Inpatient stay	No ☐ 2	Yes ☐ 1	→ If yes, provide details @ 22
	Other NHS services	No ☐ 2	Yes ☐ 1	→ If yes, provide details @ 23

21 Outpatient Appointment(s): Type of clinic (e.g. Orthopaedic, Cardiac etc)

	Number of visits to this clinic in the last 3 months

22 Inpatient stay(s) Type of department or ward (e.g. Hip replacement or Heart surgery)

	Number of days spent in hospital during last 3 months (record for each stay)

23 Other NHS Services Type of service (e.g. NHS 24)

	Number of times service used in the last 3 months

24 In the LAST 3 MONTHS, please tell us if you have used any of these medications – either prescribed for you by a doctor or bought (by you or someone else on your behalf) without a prescription?

The example shows: Your Doctor had prescribed you eye drops ONCE and you also bought eye drops from the Chemist or other shops another FIVE times in the last 3 months.

In the LAST 3 MONTHS…	DOCTOR PRESCRIBED		BOUGHT WITHOUT A PRESCRIPTION (by you or someone else) from a Chemist or other shop	
EXAMPLE: Eye drops	Yes ☑ 1 → / No ☐ 2	1	Yes ☑ 1 → / No ☐ 2	5
Pain killers	Yes ☐ 1 → / No ☐ 2	↑ Number of prescriptions in last 3 months	Yes ☐ 1 → / No ☐ 2	↑ Number of times bought without a prescription in last 3 months
Anti-inflammatory drugs *(eg: Ibuprofen)*	Yes ☐ 1 → / No ☐ 2	↑ Number of prescriptions in last 3 months	Yes ☐ 1 → / No ☐ 2	↑ Number of times bought without a prescription in last 3 months
Gels / creams *(eg: Ibuleve)*	Yes ☐ 1 → / No ☐ 2	↑ Number of prescriptions in last 3 months	Yes ☐ 1 → / No ☐ 2	↑ Number of times bought without a prescription in last 3 months
Inhalers for asthma	Yes ☐ 1 → / No ☐ 2	↑ Number of prescriptions in last 3 months	Yes ☐ 1 → / No ☐ 2	↑ Number of times bought without a prescription in last 3 months
Sleeping pills	Yes ☐ 1 → / No ☐ 2	↑ Number of prescriptions in last 3 months	Yes ☐ 1 → / No ☐ 2	↑ Number of times bought without a prescription in last 3 months
Anti-depressants	Yes ☐ 1 → / No ☐ 2	↑ Number of prescriptions in last 3 months	Yes ☐ 1 → / No ☐ 2	↑ Number of times bought without a prescription in last 3 months

25 Are you taking any other medications?

Please tick ONE box

Yes ☐ 1 → 26 → No ☐ 2 → 27 →

26 If you are taking any other medications, please write the name(s) of the medications below and indicate the number of times that this has been prescribed or bought for you IN THE LAST 3 MONTHS

NAME OF MEDICATION	DOCTOR PRESCRIBED		BOUGHT WITHOUT A PRESCRIPTION (by you or someone else) from a Chemist or other shop	
…	Yes ☐ 1 → No ☐ 2	… ↑ Number of prescriptions in last 3 months	Yes ☐ 1 → No ☐ 2	… ↑ Number of times bought without a prescription in last 3 months
…	Yes ☐ 1 → No ☐ 2	… ↑ Number of prescriptions in last 3 months	Yes ☐ 1 → No ☐ 2	… ↑ Number of times bought without a prescription in last 3 months
…	Yes ☐ 1 → No ☐ 2	… ↑ Number of prescriptions in last 3 months	Yes ☐ 1 → No ☐ 2	… ↑ Number of times bought without a prescription in last 3 months
…	Yes ☐ 1 → No ☐ 2	… ↑ Number of prescriptions in last 3 months	Yes ☐ 1 → No ☐ 2	… ↑ Number of times bought without a prescription in last 3 months
…	Yes ☐ 1 → No ☐ 2	… ↑ Number of prescriptions in last 3 months	Yes ☐ 1 → No ☐ 2	… ↑ Number of times bought without a prescription in last 3 months
…	Yes ☐ 1 → No ☐ 2	… ↑ Number of prescriptions in last 3 months	Yes ☐ 1 → No ☐ 2	… ↑ Number of times bought without a prescription in last 3 months

The next section looks at what you may have EATEN and DRUNK over the LAST 7 DAYS. Please read each question carefully, ticking the appropriate box for each option.

27 About how many times OVER the LAST 7 DAYS did you eat breakfast?

Please tick ONE box

No times	1-2 times	3-5 times	6 or more times
☐ 1	☐ 2	☐ 3	☐ 4

28 About how many times OVER the LAST 7 DAYS did you eat / drink a serving of the following?

Please tick ONE box on EACH line

	No times	1-2 times	3-5 times	6 or more times
Cheese *(any except cottage cheese)*	☐ 1	☐ 2	☐ 3	☐ 4
Beef burgers or sausages	☐ 1	☐ 2	☐ 3	☐ 4
Beef, pork or lamb	☐ 1	☐ 2	☐ 3	☐ 4
Fried food *(fried fish, cooked breakfast)*	☐ 1	☐ 2	☐ 3	☐ 4
Chips	☐ 1	☐ 2	☐ 3	☐ 4
Bacon, processed meat	☐ 1	☐ 2	☐ 3	☐ 4
Pies, quiches, pastries	☐ 1	☐ 2	☐ 3	☐ 4
Crisps	☐ 1	☐ 2	☐ 3	☐ 4
Fast foods *(takeaway or sit in)*	☐ 1	☐ 2	☐ 3	☐ 4
Nuts	☐ 1	☐ 2	☐ 3	☐ 4

29 Are you vegetarian?

Please tick ONE box

Yes ☐ 1

No ☐ 2

30 **Thinking about the LAST 7 DAYS: about how many times a day did you eat the following:**

Please tick ONE box on EACH line	Less than once a day	1-2 times a day	3-5 times a day	6 or more times a day
Fruit and vegetables *(not potatoes)*	☐ 1	☐ 2	☐ 3	☐ 4
Chocolate, sweets	☐ 1	☐ 2	☐ 3	☐ 4
Biscuits	☐ 1	☐ 2	☐ 3	☐ 4
Sugary drinks *(fizzy drinks, diluting/ fruit juice)*	☐ 1	☐ 2	☐ 3	☐ 4

31 **Thinking about the LAST 7 DAYS: about how much milk did you use in a day, for drinking or in cereal, tea or coffee?**

Please tick ONE box

Less than a quarter pint	About a quarter pint	About half a pint	1 pint or more
☐ 1	☐ 2	☐ 3	☐ 4

32 **What kind of milk do you usually use?**

Please tick ONE box

Full cream (blue top)	Semi skimmed (green top)	Skimmed (red top)
☐ 1	☐ 2	☐ 3

33 **Have you ever smoked cigarettes?**

Please tick ONE box

☐ 1 No, I've never smoked

☐ 2 No, I've quit

☐ 3 Yes, I smoke now ↓

If yes, how many do you usually smoke per day? ✎ … _____

35 Thinking about THE LAST 7 DAYS: how much alcohol have you had to drink each day?

Start yesterday and work back through week. Record number of pints, glasses etc you had each day.

Please circle which day is today ↓	BEER, LAGER CIDER *Record number of pints* 330ml bottle = ½ pint 500ml can = 1 pint	WINE *Record number of glasses* 1 bottle wine = 6 glasses	FORTIFIED WINE *Record number of glasses* 1 bottle fortified wine = 12 glasses	SPIRITS *Record number of measures* 1 bottle spirits = 27 measures ¼ bottle spirits = 7 measures	OTHER (specify) …
MONDAY	PINTS	GLASSES	GLASSES	MEASURES	
TUESDAY	PINTS	GLASSES	GLASSES	MEASURES	
WEDNESDAY	PINTS	GLASSES	GLASSES	MEASURES	
THURSDAY	PINTS	GLASSES	GLASSES	MEASURES	
FRIDAY	PINTS	GLASSES	GLASSES	MEASURES	
SATURDAY	PINTS	GLASSES	GLASSES	MEASURES	
SUNDAY	PINTS	GLASSES	GLASSES	MEASURES	

36 How old are you?

… _____ _____ years old

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

A SURVEY ASSISTANT WILL NOW HELP YOU COMPLETE THESE NEXT QUESTIONS AND TAKE YOUR PHYSICAL MEASUREMENTS

Survey Assistant IDNO | | | | Survey Assistant to complete 39 – 44 with FFIT participant

39 Food Portion Station

Ask man to look at the pictures and decide which portion most resembles what he currently eats. Record the number of the portion (1-8) against each type of food listed.

Cheese ... | **Meat** ... | **Pasta** ... | **Chips** ...

40 ASK: do you have a LONG-STANDING illness, disability or infirmity? By LONG-STANDING we mean anything that has troubled you over a period of time or that is likely to affect you over a period of time?

Please tick ONE box

Yes ☐ 2 **ASK Q 41↓** No ☐ 1 **ASK Q 41a→**

41 What is the matter with you?

Does this normally limit your activities in any way?

Please tick ONE box for EACH listed condition

write BRIEF description of all LONG-STANDING conditions mentioned	A very great deal	Quite a lot	To a moderate degree	Only a little	Not at all
1 ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2 ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3 ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4 ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5 ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6 ...	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

41a The next questions are about the health of members of your family.

Please tick ONE box on each line	Yes	No
Have either of your parents developed heart disease or stroke before the age of 60?	☐ 1	☐ 2
Have any of your brothers or sisters developed heart disease or stroke before the age of 60?	☐ 1	☐ 2
Do you know that any of your grandparents, your aunts or uncles or your first cousins (their children) developed heart disease or stroke below age 60?	☐ 1	☐ 2
If yes, how many? Number ✎	_____	

41b We would now like to ask you about any major changes in your life circumstances since we last saw you in August-October 2012.

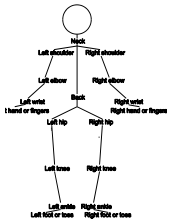
Have any of the following happened to you since we last saw you in 2012?

Please circle No or Yes			When did this happen?	How much did/does this affect your day to day life: a) at the time? b) now? Not at all … A great deal
Family and personal circumstances				
A	Serious personal illness	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10 Now? 1 2 3 4 5 6 7 8 9 10
B	Personal accident	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10 Now? 1 2 3 4 5 6 7 8 9 10
C	Moved house	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10 Now? 1 2 3 4 5 6 7 8 9 10
D	New baby	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10 Now? 1 2 3 4 5 6 7 8 9 10
E	Suffered financial hardship	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10 Now? 1 2 3 4 5 6 7 8 9 10
F	Separated	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10 Now? 1 2 3 4 5 6 7 8 9 10

Have any of the following happened to you since we last saw you in 2012?

		Please circle No or Yes	When did this happen?	How much did/does this affect your day to day life: a) at the time? b) now? Not at all … A great deal
G	Divorced	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
H	Serious illness of a close family member	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
I	Death of a close family member	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
J	Death of close friend	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
Work life				
K	Changed jobs	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
L	Got promotion	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
M	Got demoted	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
N	Started own business	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
O	Returned to work after not working for a long time	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
P	Made redundant/ laid off	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
Q	Retired	No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
				Now? 1 2 3 4 5 6 7 8 9 10
Other – Please tell us if anything else has happened to you				
✎		No 2 Yes 1	MM/YY	At the time? 1 2 3 4 5 6 7 8 9 10
✎		No 2 Yes 1	MM/YY	Now? 1 2 3 4 5 6 7 8 9 10

42 JOINT PAIN



		Pain frequency "How often do you get pain in your…?"				→	Pain severity "Is the pain…?"				Limit Activities "Does this limit your day to day activities…?"						"When did this FIRST limit your activities…?"
		All or most of the time	Only from time to time	Never	Don't Know		Severe	Moderate	Slight	Don't know	A very great deal	Quite a lot	To a moderate degree	Only a little	Or not at all	Don't know	No limitation = 7777 Before Aug 2012 = 8888 **Since we last saw you in 2012** = MMYY
Neck		1	2	3	9	complete severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	NECK M M Y Y
Back		1	2	3	9		1	2	3	9	1	2	3	4	5	9	BACK M M Y Y
Shoulder	**L**	1	2	3	9	complete severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	SHOULDER M M Y Y
	R	1	2	3	9		1	2	3	9	1	2	3	4	5	9	M M Y Y
Elbow	**L**	1	2	3	9	complete severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	ELBOW M M Y Y
	R	1	2	3	9		1	2	3	9	1	2	3	4	5	9	M M Y Y
Wrist	**L**	1	2	3	9	→ severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	WRIST M M Y Y
	R	1	2	3	9		1	2	3	9	1	2	3	4	5	9	M M Y Y
Hand/ Finger	**L**	1	2	3	9	complete severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	HAND/ FINGER M M Y Y
	R	1	2	3	9		1	2	3	9	1	2	3	4	5	9	M M Y Y
Hip	**L**	1	2	3	9	complete severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	HIP M M Y Y
	R	1	2	3	9		1	2	3	9	1	2	3	4	5	9	M M Y Y
Knee	**L**	1	2	3	9	complete severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	KNEE M M Y Y
	R	1	2	3	9		1	2	3	9	1	2	3	4	5	9	M M Y Y
Ankle	**L**	1	2	3	9	complete severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	ANKLE M M Y Y
	R	1	2	3	9		1	2	3	9	1	2	3	4	5	9	M M Y Y
Foot / Toes	**L**	1	2	3	9	complete severity & limits if freq. answer is 1, 2 or 9	1	2	3	9	1	2	3	4	5	9	FOOT / TOES M M Y Y
	R	1	2	3	9		1	2	3	9	1	2	3	4	5	9	M M Y Y

INJURIES

43 **Have you had any injuries since we last saw you (i.e. since August-October 2012)?**

Please tick ONE box

Yes ☐ 1 → 44

No ☐ 2 → Thank man & direct to Physical Measures

44 **How many injuries have you had over this period?**

Please tick ONE box

1 ☐ 1 provide details @ injury 1

2 ☐ 2 provide details @ injury 1 & 2

3+ ☐ 3 provide details @ injury 1, 2 & 3

If more than 3, record 3 most recent injuries

	Injury 1			Injury 2			Injury 3		
Brief description of injury									
What type of injury Please circle Y/N on EACH LINE	Break or fracture	Y 1	N 2	Break or fracture	Y 1	N 2	Break or fracture	Y 1	N 2
	Ligament / Cartilage / Muscle damage	Y 1	N 2	Ligament / Cartilage / Muscle damage	Y 1	N 2	Ligament / Cartilage / Muscle damage	Y 1	N 2
	Dislocation of joint	Y 1	N 2	Dislocation of joint	Y 1	N 2	Dislocation of joint	Y 1	N 2
	Severe bruising / sprain	Y 1	N 2	Severe bruising / sprain	Y 1	N 2	Severe bruising / sprain	Y 1	N 2
	Other (specify)	Y 1	N 2	Other (specify)	Y 1	N 2	Other (specify)	Y 1	N 2
Date of injury	M M Y Y			M M Y Y			M M Y Y		
Location of injury Please circle Y/N on EACH LINE	Lower Limbs Hip, Knee, Leg, Ankle, Foot, Toes	Y 1	N 2	Lower Limbs Hip, Knee, Leg, Ankle, Foot, Toes	Y 1	N 2	Lower Limbs Hip, Knee, Leg, Ankle, Foot, Toes	Y 1	N 2
	Upper Limbs Shoulder, Arm, Elbow, Hand, Fingers	Y 1	N 2	Upper Limbs Shoulder, Arm, Elbow, Hand, Fingers	Y 1	N 2	Upper Limbs Shoulder, Arm, Elbow, Hand, Fingers	Y 1	N 2
	Torso/ Upper body Back, Neck, Ribs	Y 1	N 2	Torso/ Upper body Back, Neck, Ribs	Y 1	N 2	Torso/ Upper body Back, Neck, Ribs	Y 1	N 2
	Other (specify)	Y 1	N 2	Other (specify)	Y 1	N 2	Other (specify)	Y 1	N 2
Did this injury require… Please circle Y/N on EACH LINE	Limitation of usual activities	Y 1	N 2	Limitation of usual activities	Y 1	N 2	Limitation of usual activities	Y 1	N 2
	Hospital treatment	Y 1	N 2	Hospital treatment	Y 1	N 2	Hospital treatment	Y 1	N 2
	Physiotherapy	Y 1	N 2	Physiotherapy	Y 1	N 2	Physiotherapy	Y 1	N 2
	Other treatment	Y 1	N 2	Other treatment	Y 1	N 2	Other treatment	Y 1	N 2
To what extent does this injury STILL LIMIT your day to day activities Please circle Y/N on EACH LINE	Difficulty walking	Y 1	N 2	Difficulty walking	Y 1	N 2	Difficulty walking	Y 1	N 2
	Difficulty climbing stairs	Y 1	N 2	Difficulty climbing stairs	Y 1	N 2	Difficulty climbing stairs	Y 1	N 2
	Difficulty doing physical activity	Y 1	N 2	Difficulty doing physical activity	Y 1	N 2	Difficulty doing physical activity	Y 1	N 2

PHYSICAL MEASURES

45 BLOOD PRESSURE

SURVEY ASSISTANT IDNO

TEMPERATURE . C

Sitting for at least 5 mins?

OMRON IDNO

CUFF IDNO

ARM USED? R L

SYSTOLIC *BP letter if over 140* / **DIASTOLIC** *BP letter if over 90*

PULSE

✓ IF ISSUED BP LETTER

2ND READING STAFF IDNO

2ND TEMPERATURE . C

2ND SITTING FOR 5 MINS?

2ND OMRON IDNO

2ND CUFF IDNO

ARM USED R L

SYSTOLIC / **DIASTOLIC**

PULSE

✓ IF ISSUED BP LETTER

PLEASE RECORD ANY CONCERNS WITH BP MEASUREMENTS …

48 WAIST

SURVEY ASSISTANT IDNO

WAIST 1st reading . cms

WAIST 2nd reading . cms

WAIST 3rd reading If difference between measures 1 and 2 is ≥ 0.5cm, record 3rd measure . cms

PLEASE RECORD ANY CONCERNS WITH WAIST MEASUREMENTS …

BARCODE

48 WEIGHT

SURVEY ASSISTANT IDNO | | | |

SCALES IDNO | | | | |

MEASURE KGS | | | | . |

PLEASE RECORD ANY CONCERNS WITH: WEIGHT MEASUREMENT

49 BODY COMPOSITION

Is this man eligible for body composition measurement?

Man NOT eligible if fitted with: PACEMAKER, COCHLEAR IMPLANTS OR ANY OTHER ELECTRICAL IMPLANT(s)

Eligible ☐ 1

NOT Eligible ☐ 2 RECORD REASON NOT ELIGIBLE:

SURVEY ASSISTANT IDNO | | | | **BODYSTAT IDNO** | 3 | 1 | | | | |

*** * * ATTACH ELECTRODES to RIGHT SIDE of BODY ONLY * * ***

RESTING FOR AT LEAST 3 MINUTES? (LYING DOWN) | |

TIME MEASURE TAKEN | | : | |

TEST NUMBER | | | |

LEAN Kgs | | . | | **50KHz** | | | | |

PLEASE RECORD ANY CONCERNS WITH MEASUREMENT …

THANK FOR PARTICIPATION, PROMPT RE QUESTIONNAIRE COMPLETION & DIRECT TO CHECKING STATION

QUESTIONNAIRE

	IDNO			INITIALS		
Questionnaire (Checker)						
S A H R (Completer)						

DATE OF PHYSICAL MEASURES (dd/mm/yy)

Stadium	D	D	/	M	M	/	Y	Y		
Home Visit	D	D	/	M	M	/	Y	Y		

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FOOTBALL FANS IN TRAINING