**National Residents Association EMF & RFR Health and Welfare Self-Assessment**

1. Your name, address, phone number & email address:

2. For each line, without spending too long, enter your score on the right using:-

**1** = Often, **2** = Sometimes, **3** = Hardly Ever, **4** = Never, **X** = Don’t Know

**IMPORTANT:** Put a W = Work or H= Home, by your score, if symptoms are different at work and at home.

|  |  |
| --- | --- |
|  | **Score** |
| Buzzing, ringing, hissing sounds (often called Tinnitus) or unexpected ear ache |  |
| Headaches or sharp pains in the head |  |
| Migraines |  |
| Feeling excessively tired or lacking energy |  |
| Head feels strange |  |
| Pressure behind eyes |  |
| Pressure in head |  |
| Unexpected nosebleeds or some bloodspots from nose |  |
| Racing Heart / Heart Palpitations / Heart missing beats |  |
| Can’t focus well not being able to concentrate |  |
| Forgetfulness (difficulty recalling facts, names, numbers) |  |
| Speech - not being able to get words out right |  |
| Redness of the face / face burning sensation |  |
| Severe acne |  |
| Skin crawling feeling or itchy skin |  |
| Skin rashes |  |
| Irritability |  |
| Anxiety / Feeling Anxious or on-edge |  |
| Behaviour not fully in your control |  |
| Crying or feeling like crying |  |
| Feeling agitated |  |
| Feeling depressed |  |
| Feeling happy |  |
| Having mood swings |  |
| Feeling of discomfort |  |
| Feeling of disconnection with everything about you |  |
| Feeling out of control |  |
| Don’t feel relaxed / at ease / comfortable |  |
| Feeling stressed for no apparent reason |  |
| Having Apathy (not feeling like engaging with anything) |  |
| Loss of empathy (not really thinking about or wanting to engage with others) |  |
| Lack of appetite |  |
| Nausea |  |
| Tummy pains |  |
| Joint pains |  |
| Muscle spasms |  |
| Aching or restless limbs (wanting to keep moving them) |  |
| Stabbing pains in chest / organs |  |
| Stiff Muscles and / or joints |  |
| Tooth / Gum ache |  |
| Weak limbs or heavy-feeling limbs |  |
| Can’t decide / make decisions |  |
| Feeling dizzy or having a loss of balance or poor coordination |  |
| Feeling hyperactive |  |
| Flu-like symptoms |  |
| Nerve twinges |  |
| Not wanting to make eye contact |  |
| Sleepiness during the day |  |
| Eyelids flickering / twitching |  |
| Eyes too dry or smarting |  |
| Itchy eyes |  |
| Visual disturbances |  |
| Particular sensitivity to light |  |
| Shortness of breath |  |
| Shallow non-restful sleep |  |
| Keep waking up in the night |  |
| Trouble getting off to sleep |  |
| Not experiencing dreams |  |
| Please write any other symptoms you are experiencing here: |  |

3. Please fill in your score for overall health as you see it (be honest!):-

|  |  |
| --- | --- |
|  | **Score (1-10)**  **(10 is best)** |
| Your overall Physical health score |  |
| Your overall Mental (‘how you feel’) health score |  |

**Thank you for participating in the National Residents Association Survey.**