**SHIFT Study - Baseline Case Report Form**

Date of visit / consent:

(DD/MM/YYYY) / /

If consent was not given, please state reason (please tick):

|  |  |
| --- | --- |
| Failed to attend |  |
| Absent |  |
| Left company |  |
| Job commitment/not available |  |
| Does not want to participate |  |
| Other (please specify below) |  |

*Please state if Other reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Arm to which the participant is allocated (please tick):*

|  |  |
| --- | --- |
| Control |  |
| Intervention |  |

**Physiological measures**

**Blood pressure** (systolic/diastolic) **Heart rate**

To be taken after a *20-minute* rest in the seated position, using the left arm level with the heart

Measure 1: / mm/Hg bpm

Measure 2: / mm/Hg bpm

Measure 3: / mm/Hg bpm

|  |
| --- |
| Average of measures 2 and 3 (to be calculated in the database):  / mm/Hg bpm |

*Not completed report why: \_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Prompt for the researcher: Stroop test (5’)***

The blood pressure cuff should remain on the participant’s left arm after the blood pressure measure.

**Mirror tracing task**

Blood pressure and heart rate to be taken at 2’15’’ (measure 1) and at 4’35’’ (measure 2). The blood pressure cuff should remain on the participant’s left arm after the blood pressure measure. If the participant is left handed, they should complete the test with their right hand.

|  |  |
| --- | --- |
| **What hand did the participant use to complete the task?** | |
| Right | Left |

**Blood pressure** (systolic/diastolic) **Heart rate**

Measure 1: / mm/Hg bpm

Measure 2: / mm/Hg bpm

Number of errors

**On a scale of 1 to 5, how stressed did you feel during this task?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 |

Very stressed

Not stressed at all

*Not completed report why: \_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hand- grip strength**

To be taken while sitting. The elbow of the arm holding the dynamometer will be placed against the side of the body and bent to a 90° angle. Participants need to squeeze the handle of the dynamometer as hard as they can for 3 seconds. Note down the best of 3 attempts. Alternate hands.

Right hand . kg

Left hand . kg

|  |
| --- |
| Average of right and left hand (to be calculated in the database):  / Kg |

**Finger prick blood samples**

To be taken after heating the hand in hot water for 5-minutes and disinfecting the chosen finger for the test.

HbA1c . mmol/mol

Triglycerides . mmol/l

HDL Cholesterol . mmol/l

LDL Cholesterol . mmol/l

Total Cholesterol **.**  mmol/l

*Not completed report why: \_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Standing height** (record to nearest 0.1 cm): . cm

*Not completed report why:*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tanita scale measurements completed (please tick):** YesNo

*Not completed report why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |  |
| --- | --- | --- |
| Asked participant if they have a pacemaker or other implanted medical device? | Yes | No |
| Do they have a pacemaker? (if yes, do not use impedance mode, just use weight mode) | Yes | No |

Clothes weight tare 1.0 kg Tick if socks/tights worn

Weight: . kg

Body fat %: . %

Fat mass: . kg

Fat free mass: . kg

BMI (to be calculated in the database): . kg/m2

|  |  |  |
| --- | --- | --- |
| *Attached paper print out to this page of the CRF?* | Yes | No |

**Anthropometric measurements** (record to nearest 0.1 cm):

Waist circumference . cm

Hip circumference . cm

Waist/hip ratio (to be calculated in the database): .

Neck circumference . cm

*Not completed report why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Health Screen Questionnaire for Study Volunteers**

This Health Screen Questionnaire is to confirm that you are fit to participate in this study.

If you have a blood-borne virus (e.g. HIV, Hepatitis B or C, malaria) or think that you may have one, please do not take part in this research.

**1. At present,** do you have any health problem for which you are:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (a) | on medication, prescribed or otherwise | Yes |  | No |  |
| *If yes to taking medication, please complete the Current Medications Log.* | | | | | | |
| (b) | attending your general practitioner | Yes |  | No |  |
| (c) | on a hospital waiting list | Yes |  | No |  |

**2**. **In the past two years,** have you had any illness or injury which required you to:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (a) | consult your GP | Yes |  | No |  |
| (b) | attend a hospital outpatient department | Yes |  | No |  |
| (c) | be admitted to hospital | Yes |  | No |  |

**3.** **Have you ever** had any of the following:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (a) | Convulsions/epilepsy | Yes |  | No |  |
| (b) | Asthma | Yes |  | No |  |
| (c) | Eczema | Yes |  | No |  |
| (d) | A blood disorder (e.g. MDS, Haemophilia, anaemia) | Yes |  | No |  |
| (e) | Head injury | Yes |  | No |  |
| (f) | Digestive problems | Yes |  | No |  |
| (g) | Heart problems/chest pains...……………… | Yes |  | No |  |
| (h) | Problems with muscles, bones or joints | Yes |  | No |  |
| (i) | Disturbance of balance/coordination | Yes |  | No |  |
| (j) | Numbness in hands or feet | Yes |  | No |  |
| (k) | Disturbance of vision | Yes |  | No |  |
| (l) | Ear/hearing problems | Yes |  | No |  |
| (m) | Thyroid problems | Yes |  | No |  |
| (n) | Chronic kidney or liver problems | Yes |  | No |  |
| (o) | Problems with blood pressure | Yes |  | No |  |

**If YES to any question, please describe briefly if you wish** **(e.g. to confirm problem was/is short-lived, insignificant or well controlled.)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Physical activity and family history**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (a) | Are you physically active (30 minutes of moderate intensity physical activity on at least 5 days each week for at least 3 months)? | Yes |  | No |  |
| (b) | Has any, otherwise healthy, member of your family under the age of 35 died suddenly during or soon after exercise? | Yes |  | No |  |

##### **Allergy Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (a) | Are you allergic to plasters? | Yes |  | No |  |
| (b) | Are you allergic to latex? | Yes |  | No |  |

**If YES to any of the above, please provide additional information on the allergy**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### **Additional questions for female participants**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| (a) | Are your periods normal/regular? | Yes |  | No |  |
| (b) | Are you on “the pill”? | Yes |  | No |  |
| (c) | Could you be pregnant? | Yes |  | No |  |
| (d) | Are you taking hormone replacement therapy (HRT)? | Yes |  | No |  |

**7.** **Please complete the form below regarding any current medications you are taking.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Type** | **Yes** | **No** | **Reason for medication** (e.g. high blood pressure) |
| ACE Inhibitor |  |  |  |
| Alpha-Blocker |  |  |  |
| ARB |  |  |  |
| Beta-Blocker |  |  |  |
| Calcium Channel Blocker |  |  |  |
| Diuretics/Thiazides |  |  |  |
| Aspirin |  |  |  |
| Lipid Lowering – Statin |  |  |  |
| Lipid Lowering – Fibrate |  |  |  |
| Steroids  Oral: □ Injected:□  Inhaled:□ |  |  |  |
| Anti-Thyroid Medication |  |  |  |
| Thyroxin Replacement |  |  |  |
| Multi-Vitamins |  |  |  |
| Vitamin C |  |  |  |
| Vitamin D |  |  |  |

**8. QRISK3**

Information collected below will help us to assess your risk of suffering from heart disease within the next 10 years.

*please tick “yes” or “no”*

|  |  |  |
| --- | --- | --- |
| **Do you have any of the following?** | **Yes** | **No** |
| Has a direct member of your family had angina or a heart attack when they were younger than 60 years old? |  |  |
| Atrial Fibrillation |  |  |
| Migraines |  |  |
| Rheumatoid arthritis |  |  |
| Systemic lupus erythematosus (SLE) |  |  |
| Severe mental illness (e.g. schizophrenia, bipolar disorder and moderate/severe depression) |  |  |
| Are you on atypical antipsychotic medication? |  |  |
| Diagnosis of or treatment for erectile dysfunction? |  |  |

**Demographic information**

**Date of birth (DD/MM/YYYY):** / /

**Sex (please tick):** Male Female

**Shift (please tick):** Morning Afternoon Night

**Duration working at the company:** years months

**Duration working as a HGV driver:** years months

**Average hours worked per week:**

*(this might differ from your contracted hours)*

|  |
| --- |
| **Postcode:** |

*For researcher use only:*

Please follow this link: <http://dclgapps.communities.gov.uk/imd/idmap.html> to obtain the Index of Multiple Deprivation (IMD), using the postcode provided above.

**IMD:**

**Marital Status (please tick):**

|  |  |  |  |
| --- | --- | --- | --- |
| Single……………………………………… |  | Separated…… |  |
| Co-habiting ………………………………. |  | Divorced…….. |  |
| Married (including those in civil partnerships – 1st marriage) ………. |  | Widowed……. |  |
| Re-married ……………………………….. |  | Other………… |  |

*Please state if Other Marital Status:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Level of Education (please tick):**

|  |  |  |  |
| --- | --- | --- | --- |
| GCSEs or equivalent (e.g. O-level, CSE) …………………... |  | Master’s degree………………………. |  |
| A-levels……………………….. |  | Professional or Doctorate degree…... |  |
| University graduate (e.g. Bachelor’s degree)………… |  | Other …………………………………... |  |

*Please state if Other Level of Education:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate at what age you left school: years

**Ethnicity (please tick):**

|  |  |  |  |
| --- | --- | --- | --- |
| White British………………… |  | Pakistani………………. |  |
| White Irish…………………... |  | Bangladeshi…………… |  |
| Other White…………………. |  | Other Asian…………… |  |
| White and Black Caribbean.. |  | Black Caribbean……… |  |
| White and Black African…… |  | Black African………….. |  |
| White and Asian……………. |  | Other Black……………. |  |
| Other Mixed……………….… |  | Chinese………………… |  |
| Indian………………………… |  | Another Ethnic Group… |  |

*Please state if Another Ethnic Group:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have diabetes (please tick):** Yes No

If Yes, please indicate what type of diabetes (please tick):

Diabetes Type 1 Diabetes Type 2

If Yes**,** please state how it is controlled (please tick):

Medical treatment Lifestyle

**On an average week, please tick how often you eat at least ONE portion of the following foods & drinks**: (a portion includes: a handful of grapes, an orange, a serving of carrots, a side salad, a slice of bread, a glass of pop).

*(Please only put one tick, but answer* ***EVERY*** *line)*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Rarely or never** | **Less than 1 a Week** | **Once a Week** | **2-3 times a Week** | **4-6 times a Week** | **1-2 times a Day** | **3-4 times a Day** | **5+ a Day** |
| Fruit (tinned / fresh) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Fruit juice (not cordial or squash) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Salad (not garnish added to sandwiches) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Vegetables (tinned / frozen / fresh but not potatoes) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Chips / fried potatoes | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Beans or pulses like baked beans, chick peas, dahl | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Fibre-rich breakfast cereal, like Weetabix, Fruit ‘n Fibre, Porridge, Muesli | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Wholemeal bread or chapattis | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Cheese / yoghurt | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Crisps / savoury snacks | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Sweet biscuits, cakes, chocolate, sweets | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Ice cream / cream | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Non alcoholic fizzy drinks/pop  (not sugar free or diet) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Rarely or never** | **Less than 1 a Week** | **Once a Week** | **2-3 times a Week** | **4-6 times a Week** | **7+ times a week** |
| **Whole meats:** |  |  |  |  |  |  |
| Beef, Lamb, Pork, Ham - steaks, roasts, joints, mince or chops | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Chicken or Turkey – steaks, roasts, joints, mince or portions (not in batter or breadcrumbs) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| **Processed meats/ meat products** | |  |  |  |  |  |
| Sausages, bacon, corned beef, meat pies/pasties, burgers | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Chicken/turkey nuggets/twizzlers, turkey burgers, chicken pies, or in batter or breadcrumbs | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| **Fish:** |  |  |  |  |  |  |
| White fish in batter or breadcrumbs – like ‘fish ‘n chips’ | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| White fish not in batter or breadcrumbs | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |
| Oily fish – like herrings, sardines, salmon, trout, mackerel, fresh tuna (not tinned tuna) | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 | 🞎 |

**Smoking and alcohol use**

**What is your current smoking status? (please tick)**

Never smoked

Ex-smoker

Current smoker

If current, please report how many cigarettes you smoke per day: \_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the answer most relevant to you in the questions below

1. **How often do you have a drink containing alcohol?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Never | Monthly or | 2 to 4 | 2 to 3 | 4 or more times |
|  | less | times a month | times a week | a week |

1. **How many units of alcohol do you have on a typical day when you are drinking?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more |

***Note: Check the units chart to work out the number of units contained in each drink****.*

**Musculoskeletal Problems:** The following questions refer to trouble experienced in muscles and joints which have progressively come about. Please answer every question even if you have never had trouble in any parts of your body. This picture shows how the body has been divided. You should decide for yourself which part (if any) is or has been affected.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Nordic Person |  | Have you at any time during the **past month** had trouble (such as ache, pain, discomfort, numbness) in**:** | | | | | | | | | | |
|  | 0  No trouble | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10  Severe trouble |
| **NECK** |  |  |  |  |  |  |  |  |  |  |  |
| **SHOULDER** |  |  |  |  |  |  |  |  |  |  |  |
| **UPPER BACK** |  |  |  |  |  |  |  |  |  |  |  |
| **ELBOW** |  |  |  |  |  |  |  |  |  |  |  |
| **WRIST/HAND** |  |  |  |  |  |  |  |  |  |  |  |
| **LOWER BACK** |  |  |  |  |  |  |  |  |  |  |  |
| **HIP/THIGH** |  |  |  |  |  |  |  |  |  |  |  |
| **KNEE** |  |  |  |  |  |  |  |  |  |  |  |
| **ANKLE/FEET** |  |  |  |  |  |  |  |  |  |  |  |

**Hospital Anxiety and Depression Scale (HADS)**

**Instructions -** Read every sentence. Place an X on the answer that best describes how you have been feeling during the **LAST WEEK**. For these questions, spontaneous answers are the most important.

|  |  |
| --- | --- |
| 1. I feel tense or wound up  Most of the time  A lot of the time  From time to time  Not at all  3. I get a sort of frightened feeling as if something awful is about to happen  Very definitely and quite badly  Yes, but not too badly  A little but it doesn’t worry me  Not at all  5. Worrying thoughts go through my mind  A great deal of the time  A lot of the time  From time to time but not often  Only occasionaly  7. I can sit at ease and feel relaxed  Definitely  Usually  Not often  Not at all  9. I get a sort of frightened feeling like  butterflies in the stomach  Not at all  Occasionally  Quite often  Very often | 2. I still enjoy the things I used to enjoy  Hardly at all  Only a little  Not quite as much  Definitely as much  4. I can laugh and see the funny side of things  Not at all  Definitely not so much now  Not quite as much now  As much as I always could    6. I feel cheerful  Not at all  Not often  Sometimes  Most of the time  8. I feel as if I am slowed down  Nearly all of the time  Very often  Sometimes  Not at all  10. I have lost interest in my appearance  Definitely  I don’t take as much care as I should  I may not take quite as much care  I take just as much care as ever |

|  |  |
| --- | --- |
| 11. I feel restless, as if I have to be on the  move  Very much indeed  Quite a lot  Not very much  Not at all  13. I get a sudden feeling of panic  Very often indeed  Quite often  Not very often  Not at all | 12. I look forward with enjoyment to things  As much as I ever did  Rather less than I used to  Definitely less than I used to  Hardly at all    14. I can enjoy a good TV or radio programme or book  Often  Sometimes  Not often  Very seldom |

**Social Isolation – Short Form**

**Please respond to each item by marking with a “X” one box per row.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Never** | **Rarely** | **Sometimes** | **Usually** | **Always** |
| I feel left out……………………………. |  |  |  |  |  |
| I feel that people barely know me…… |  |  |  |  |  |
| I feel isolated from others ................... |  |  |  |  |  |
| I feel that people are around me but not with me ……………………………. |  |  |  |  |  |
| I feel isolated even when I am not alone……………………………………. |  |  |  |  |  |
| I feel that people avoid talking to me... |  |  |  |  |  |
| I feel detached from other people ....... |  |  |  |  |  |
| I feel like a stranger to those around me……………………………………….. |  |  |  |  |  |

**Utrecht Work Engagement Scale**

The following 9 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, circle “0” (zero) in the space after the statement. If you have had this feeling, indicate how often you feel it by crossing the number (from 1 to 6) that best describes how frequently you feel that way.

0 = never 4 = often (once a week)

1 = almost never (a few times a year or less) 5 = very often (a few times a week)

2 = rarely (once a month or less) 6 = always (every day)

3 = sometimes (a few times a month)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| At my work, I feel bursting with energy | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| At my job, I feel strong and vigorous | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I am enthusiastic about my job | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| My job inspires me | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| When I get up in the morning, I feel like going to work | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I feel happy when I am working intensely | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I am proud of the work that I do | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I am immersed in my work | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| I get carried away when I am working | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Occupational Fatigue Exhaustion Recovery (OFER 15) Scale**  These statements are about your experience of FATIGUE and STRAIN at work and home OVER THE LAST 6 MONTHS. Please circle a number from 0-6. | | | | | | | | |
|  | **Strongly**  **Disagree** | **Disagree** | **Slightly**  **Disagree** | **Neither**  **Agree or Disagree** | **Slightly**  **Agree** | **Agree** | **Strongly Agree** |
| 1) I often feel I’m ‘at the end of my rope’ with my work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 2) I often dread waking up to another day of my work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 3) I often wonder how long I can keep going at my work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 4) I feel that most of the time I’m just “living to work” | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 5) Too much is expected of me in my work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 6) After a work shift I have little energy left | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 7) I usually feel exhausted when I get home from work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 8) My work drains my energy completely every day | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 9) I usually have lots of energy to give to my family or friends | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 10) I usually have plenty of energy left for my hobbies and other activities after I finish work | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 11) I never have enough time between shifts to recover my energy completely | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 12) Even if I’m tired from shift, I’m usually refreshed by the start of the next shift | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 13) I rarely recover my strength fully between shifts | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 14) Recovering from work fatigue between shifts isn’t a problem for me | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| 15) I’m often still feeling fatigued from one shift by the time I start the next one | 0 | 1 | 2 | 3 | 4 | 5 | 6 |

**Job Satisfaction**

Please **circle** the answer (from 1 to 7) where 1= dissatisfied and 7 = extremely satisfied.

**How satisfied are you with your job in general?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Job Performance**

Please **circle** the answer (from 1 to 7) where 1= very poorly and 7 = extremely well.

**How well do you think you have performed in your job recently?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Sickness Absence**

**Have you been absent from work due to sickness in the last 6 months?**

**Yes No**

If **yes,** how many *times* have you called in sick in the past 6 months? (please write the number of times in the corresponding box)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 day of sick leave........................ |  |  | 11 to 15 consecutive days on sick leave…………………………………….. |  |
| 2 to 5 consecutive days on sick leave………………………………... |  |  | 16 to 20 consecutive days on sick leave………………………………...….. |  |
| 6 to 10 consecutive days on sick leave………………………………… |  |  | More than 20 consecutive days sick leave……………………………………. |  |

What is the *total*number of days of missed work because of sick leave in the past six months?…….

**Presenteeism**

**In the past 6 months, have you come into work despite feeling unwell?**

**Yes No**

If **yes,** how many *times* have you come into work despite feeling unwell in the past 6 months? (please write the number of times in the corresponding box)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 day……………….………………. |  |  | 11 to 15 consecutive days…………… |  |
| 2 to 5 consecutive days………….. |  |  | 16 to 20 days consecutive days…….. |  |
| 6 to 10 consecutive days………… |  |  | More than 20 consecutive days……... |  |

What is the *total* number of days you have come into work despite not feeling well in the past six months?….

**If you assume your current work ability at its best has a value of '10' points and at its worst '0'. How many points would you give your current workability?**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Work Demands Questionnaire** *(Please tick the corresponding box)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Never | Rarely | Some-times | Often | Always |
| Different groups at work demand things from me that are hard to combine……………………………………………... |  |  |  |  |  |
| I have unachievable deadlines…………………………….. |  |  |  |  |  |
| I have to work very intensively…………………………….. |  |  |  |  |  |
| I have to neglect some tasks because I have too much to do…………………………………………………………... |  |  |  |  |  |
| I am unable to take sufficient breaks……………………… |  |  |  |  |  |
| I am pressured to work long hours…...…………………… |  |  |  |  |  |
| I have to work very fast…………………………………….. |  |  |  |  |  |
| I have unrealistic time pressures……………………….…. |  |  |  |  |  |
| I can decide when to take a break………………………… |  |  |  |  |  |
| I have a say in my own work speed………………………. |  |  |  |  |  |
| I have a choice in deciding how I do my work…………… |  |  |  |  |  |
| I have a choice in deciding what I do at work……………. |  |  |  |  |  |
| I have some say over the way I work……………………... |  |  |  |  |  |
| My working time can be flexible…………………………… |  |  |  |  |  |
| I am given supportive feedback on the work I do………... |  |  |  |  |  |
| I can rely on my line manager to help me out with a work problem…………………………………………………….… |  |  |  |  |  |
| I can talk to my line manager about something that has upset or annoyed me about………………………………... |  |  |  |  |  |
| I am supported through emotionally demanding work….. |  |  |  |  |  |
| My line manager encourages me at work……….............. |  |  |  |  |  |
| If works get difficult, my colleagues will help me………… |  |  |  |  |  |
| I get help and support I need from colleagues….............. |  |  |  |  |  |
| I receive the respect at work I deserve from my colleagues……………………………………………………. |  |  |  |  |  |
| My colleagues are willing to listen to my work-related problems……………………………………………………... |  |  |  |  |  |

**Karolinska Sleepiness Scale**

|  |  |  |  |
| --- | --- | --- | --- |
| **How sleepy are you feeling right now? (please tick in the most appropriate)** | | | |
| Extremely alert……………………….. |  | Some signs of sleepiness………………… |  | |
| Very alert……………………………... |  | Sleep but no effort to keep awake………. |  | |
| Alert…………………………………… |  | Sleepy some effort to keep awake…….... |  | |
| Rather alert…………………………… |  | Very sleepy great effort to keep awake, fighting sleep………………………………. |  | |
| Neither alert nor sleepy……………... |  |  |  | |

# Morningness-Eveningness Questionnaire

**Self-Assessment Version (MEQ-SA)**

For each question, please select the answer that best describes you by ticking the box that best indicates how you have felt in recent weeks.

1. **Approximately what time would you get up if you were entirely free to plan your day?**

|  |  |
| --- | --- |
| 5:00 AM – 6:30 AM (05:00–06:30 h)…… | 5 |
| 6:30 AM – 7:45 AM (06:30–07:45 h)…… | 4 |
| 7:45 AM – 9:45 AM (07:45–09:45 h)…… | 3 |
| 9:45 AM – 11:00 AM (09:45–11:00 h)….. | 2 |
| 11:00 AM – 12 noon (11:00–12:00 h)….. | 1 |

1. **During the first half hour after you wake up in the morning, how do you feel?**

|  |  |
| --- | --- |
| Very tired…………………………… | 1 |
| Fairly tired………………………….. | 2 |
| Fairly refreshed…………………….. | 3 |
| Very refreshed……………………... | 4 |

1. **At approximately what time in the evening do you feel tired, and as a result, in need of sleep?**

|  |  |
| --- | --- |
| 8:00 PM – 9:00 PM (20:00–21:00 h)…… | 5 |
| 9:00 PM – 10:15 PM (21:00–22:15 h)..... | 4 |
| 10:15 PM – 12:45 AM (22:15–00:45 h)… | 3 |
| 12:45 AM – 2:00 AM (00:45–02:00 h)….. | 2 |
| 2:00 AM – 3:00 AM (02:00–03:00 h)....... | 1 |

1. **At *approximately* what time of day do you usually feel your best?**

|  |  |
| --- | --- |
| 5:00 AM – 8:00 AM (05:00-08:00 h)*….…* | 5 |
| 8:00 AM – 10:00 AM (08:00-10:00 h).*….* | 4 |
| 10:00 AM – 5:00 PM (10:00-17:00 h).*.....* | 3 |
| 5:00 PM – 10:00 PM (17:00-22:00 h).*….* | 2 |
| 10:00 PM – 5:00 AM (22:00-05:00 h)….. | 1 |

1. **One hears about “morning types” and “evening types.” Which one of these types do you consider yourself to be?**

|  |  |
| --- | --- |
| Definitely a morning type………………………………….. | 6 |
| Rather more a morning type than an evening type…….. | 4 |
| Rather more an evening type than a morning type…….. | 2 |
| Definitely an evening type…………………………………. | 1 |

Total points for all 5 questions

(to be calculated in the database):

**Self-reported Driver Safety Behaviour**

To what extent do you agree or disagree with the following statements? *(please tick the relevant box on each line)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Strongly disagree | disagree | Neither disagree or agree | Agree | Strongly agree |
| I occasionally jump to get out of my lorry quickly |  |  |  |  |  |
| I always comply with the posted speed limits |  |  |  |  |  |
| I occasionally drive without getting enough sleep |  |  |  |  |  |
| I always use my log book legally |  |  |  |  |  |
| When I’m tired or rushed, I sometimes skip the daily vehicle inspection |  |  |  |  |  |
| I sometimes find myself in a difficult situation without having a way out |  |  |  |  |  |

|  |  |
| --- | --- |
| Under each heading, please tick the ONE box that best describes your health TODAY. | |
| MOBILITY |  |
| I have no problems in walking about……………………………………………….. | ❑ |
| I have slight problems in walking about……………………………………………. | ❑ |
| I have moderate problems in walking about………………………………………. | ❑ |
| I have severe problems in walking about………………………………………….. | ❑ |
| I am unable to walk about…………………………………………………………… | ❑ |
| SELF-CARE |  |
| I have no problems washing or dressing myself………………………………..… | ❑ |
| I have slight problems washing or dressing myself………………………………. | ❑ |
| I have moderate problems washing or dressing myself………………………….. | ❑ |
| I have severe problems washing or dressing myself…………………………….. | ❑ |
| I am unable to wash or dress myself………………………………………………. | ❑ |
| USUAL ACTIVITIES *(e.g. work, study, housework, family or leisure activities)* |  |
| I have no problems doing my usual activities……………………………………... | ❑ |
| I have slight problems doing my usual activities………………………………….. | ❑ |
| I have moderate problems doing my usual activities…………………………….. | ❑ |
| I have severe problems doing my usual activities………………………………… | ❑ |
| I am unable to do my usual activities………………………………………………. | ❑ |
| PAIN / DISCOMFORT |  |
| I have no pain or discomfort………………………………………………………… | ❑ |
| I have slight pain or discomfort……………………………………………………... | ❑ |
| I have moderate pain or discomfort………………………………………………… | ❑ |
| I have severe pain or discomfort……………………………………………………. | ❑ |
| I have extreme pain or discomfort………………………………………………….. | ❑ |
| ANXIETY / DEPRESSION |  |
| I am not anxious or depressed……………………………………………………… | ❑ |
| I am slightly anxious or depressed…………………………………………………. | ❑ |
| I am moderately anxious or depressed……………………………………………. | ❑ |
| I am severely anxious or depressed……………………………………………….. | ❑ |
| I am extremely anxious or depressed……………………………………………… | ❑ |

The best health you can imagine

10

0

20

30

40

50

60

80

70

90

100

5

15

25

35

45

55

75

65

85

95

|  |
| --- |
| We would like to know how good or bad your health is TODAY. |
| This scale is numbered from 0 to 100. |
| 100 means the best health you can imagine. 0 means the worst health you can imagine. |
| Mark an X on the scale to indicate how your health is TODAY. |
| Now, please write the number you marked on the scale in the box below. |

YOUR HEALTH TODAY =

The worst health you can imagine

**Health-related Resource Use Questionnaire**

**In the last 6 months, what contact have you had with any of these health services?**

|  |  |  |
| --- | --- | --- |
|  | Have you had contact with? (please circle YES or NO) | If yes, please state number of contacts you have had in the last 6 months |
| General practitioner (GP) - Surgery visit | YES NO |  |
| General practitioner (GP) - Home visit | YES NO |  |
| General practitioner (GP) - Phone call | YES NO |  |
| General practice Nurse - Surgery visit | YES NO |  |
| General practice Nurse - Home visit | YES NO |  |
| General practice Nurse - Phone call | YES NO |  |
| Occupational Health Nurse | YES NO |  |
| Mental health nurse | YES NO |  |
| Physiotherapist | YES NO |  |
| Other counsellor/therapist (please state): | YES NO |  |
| Accident and Emergency Visit | YES NO |  |
| NHS Walk-in Centre Visit | YES NO |  |
| NHS Urgent Care Centre Visit | YES NO |  |
| Hospital Outpatient appointment | YES NO |  |

**In the last 6 months have you been admitted to hospital for overnight stays?**

YES / NO (please circle)

**If Yes**, please list details of each admission below if applicable:

|  |  |
| --- | --- |
| Reason for admission | Number of days |
|  |  |
|  |  |
|  |  |
|  |  |

***Note: for researcher use ONLY:***

**Objective measures**

GENEactiv no:

GENEactiv placed on participant’s non-dominant wrist (please tick)? Yes No



Please state the time the GENEactive was fitted at (please use the 24-hour clock, HH:MM):

:

Please state the time and the date the GENEactive was initialised for (please use the 24-hour clock, HH:MM):

Time: : Date: / /

If the GENEactiv was not fitted on the participant, please tick reason below

|  |  |
| --- | --- |
| Participant does not want to wear the monitor |  |
| Participant is not allowed to wear anything on their wrist |  |
| Other |  |

Please state if other reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

activPAL no:

activPAL placed on the participant’s thigh (same side of the body as the GENEactiv -please tick)?

Yes No

Please state the time the activPAL was fitted at (please use the 24-hour clock, HH:MM):

:

Please state the time and the date the activPAL was initialised for (please use the 24-hour clock, HH:MM):

Time: : Date: / /

If the activPAL was not fitted on the participant, please tick reason below

|  |  |
| --- | --- |
| Participant does not want to wear the monitor |  |
| Participant is not allowed to wear a monitor on the thigh |  |
| Participant is allergic to the pad used to stick the activPAL on the thigh |  |
| Other |  |

Please state if other reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please go back through the questionnaire now to check all sections are complete**.

Questionnaires/tests returned/completed (please tick)

|  |  |  |
| --- | --- | --- |
| Consent form | Yes | No |
| Physiological measures | Yes | No |
| Health Screen Questionnaire | Yes | No |
| Demographic information | Yes | No |
| FFQ | Yes | No |
| Smoking and alcohol use | Yes | No |
| Nordic Musculoskeletal Questionnaire | Yes | No |
| Hospital Anxiety and Depression Scale (HADS): | Yes | No |
| Social Isolation – Short Form | Yes | No |
| Utretcht Work Engagement scale | Yes | No |
| OFER scale | Yes | No |
| Job satisfaction scale | Yes | No |
| Job performance scale | Yes | No |
| Self-reported sickness absence | Yes | No |
| Self-reported presenteeism | Yes | No |
| Work ability question | Yes | No |
| Work Demands Questionnaire | Yes | No |
| Karolinska Sleepiness Scale | Yes | No |
| Morningness-Eveningness Questionnaire | Yes | No |
| Self-reported Driver Safety Behaviour questionnaire | Yes | No |
| Self-reported EQ5D | Yes | No |
| Health-related resource use questionnaire | Yes | No |
| activPAL and GENEActiv | Yes | No |

1. Were there any sections or questions that the participant could not, or found difficult to complete?

Yes No

If Yes, which section(s) (please write the title and page)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the problem?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any concerns about the validity of the data you have collected?

Yes No

Please write any concerns here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **CRF Questionnaire Sign-Off** |
| CRF section completed by (*insert name*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of completion (DD/MM/YYYY) / / |