HEALTH / ACTIVITY INFORMATION

Balance and Mobility Screening and Assessment

Name: _____

Address: _____

_____

Phone: _____ **Email:** _____

Mobile: _____ **Gender:** male female

Date of Birth: _____ **Age:** _____ **Height:** _____ **Weigh:** _____

1. Have you ever been diagnosed as having any of the following conditions?			If Yes Year of Diagnoses
Heart attack	☐Yes	☐No	
Transient ischemic attack	☐Yes	☐No	_____
Angina (chest pain)	☐Yes	☐No	_____
High blood pressure	☐Yes	☐No	_____
Stroke	☐Yes	☐No	_____
Peripheral vascular disease	☐Yes	☐No	_____
Diabetes	☐Yes	☐No	_____
Neuropathies (problems with sensations)	☐Yes	☐No	_____
Respiratory disease	☐Yes	☐No	_____
Parkinson's disease	☐Yes	☐No	_____
Multiple sclerosis	☐Yes	☐No	_____
Polio/Post polio syndrome	☐Yes	☐No	
Epilepsy/seizures	☐Yes	☐No	_____
Other neurological conditions	☐Yes	☐No	_____
Osteoporosis	☐Yes	☐No	_____
			_____

HEALTH / ACTIVITY INFORMATION

Rheumatoid arthritis	☐Yes	☐No	_____
Other arthritic conditions	☐Yes	☐No	_____
Visual/depth perception problems	☐Yes	☐No	_____
Inner ear problems /Recurrent ear infections	☐Yes	☐No	_____
Cerebellar problems (ataxia)	☐Yes	☐No	_____
Other movement disorders	☐Yes	☐No	_____
Chemical dependency (alcohol and/or drugs)	☐Yes	☐No	_____
Depression	☐Yes	☐No	_____
Joint replacement	☐Yes	☐No	_____

If YES, how many times?

_____

☐ Right Hip
☐ Left Hip
☐ Right Knee
☐ Left Knee

Continued on the next page.

HEALTH / ACTIVITY INFORMATION

2. Please indicate your ability to do each of the following. (Place an "x" in the most appropriate box).

	Can do	Can do with some difficulty	Can do with a lot of difficulty	Cannot do without help	Cannot do at all
a. Take care of own personal needs (e.g., dressing yourself)	☐	☐	☐	☐	☐
b. Bathe yourself, using tub or shower	☐	☐	☐	☐	☐
c. Climb up and down a flight of stairs (e.g., second story	☐	☐	☐	☐	☐
d. Do light household activities (e.g., cooking, dusting, washing dishes, sweeping a walkway)	☐	☐	☐	☐	☐
e. Do heavy household activities (e.g., scrubbing floors, vacuuming, raking leaves)	☐	☐	☐	☐	☐
f. Do own shopping for groceries or clothes.	☐	☐	☐	☐	☐
g. Walk outside one or two blocks)	☐	☐	☐	☐	☐
h. Walk ½ mile (6-7 blocks)	☐	☐	☐	☐	☐
i. Walk 1 mile (12-14 blocks)	☐	☐	☐	☐	☐
j. Lift and carry 10 pounds (e.g., a full bag of groceries)	☐	☐	☐	☐	☐
k. Lift and carry 25 pounds (e.g., medium-to-large suitcase)	☐	☐	☐	☐	☐
l. Do strenuous activities (e.g., hiking, calisthenics, moving heavy objects, bicycling, aerobic dance activities, strenuous digging in garden)	☐	☐	☐	☐	☐

HEALTH / ACTIVITY INFORMATION

3. In general, how would you rate the quality of your life? (Circle the appropriate number)

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

very low low moderate high very high

4. Choose the answer that best expresses how you felt over the course of the past week:

a. Are you basically satisfied with your life? ☐Yes ☐No

b. Do you often get bored? ☐Yes ☐No

c. Do you often feel helpless? ☐Yes ☐No

d. Do you prefer to stay at home rather than going out and doing new things?

☐Yes ☐No

5. How much "bodily pain" have you generally had during the past 4 weeks? (While doing normal activities of daily living):

☐**None** ☐**Very little** ☐**Moderate** ☐**Quite a bit** ☐**Severe**

6. In a typical week, how often do you leave your house? (to run errands, go to work, go to meetings, classes, church, social functions, etc.)

☐less than once/week ☐3-4 times/week

☐1-2 times/week ☐most every day

7. Do you currently participate in regular physical exercise (such as walking, sports, exercise classes, house work or yard work) that is strenuous enough to cause a noticeable increase in breathing, heart rate, or perspiration?

☐Yes ☐No

If yes, how many days per week?

☐One ☐Two ☐Three ☐Four ☐Five ☐Six ☐Seven

Continued on the next page

HEALTH / ACTIVITY INFORMATION

8. When you go for walks (if you do), which of the following best describes your walking pace:

☐ Strolling (easy pace, takes 30 min. or more to walk a mile)

☐ Average or normal (can walk a mile in 20-30 minutes)

☐ Fairly brisk (fast pace, can walk a mile in 15-20 minutes)

☐ Do not go for walks on a regular basis

9. Did you require assistance in completing this form?

☐ None (or very little) ☐ Needed quite a bit of help

Reason: _____

10. How concerned are you about falling?

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

Not at all a little moderately very extremely

11. Have there been any changes in your medication since the start of the program (dosage/type)?

Type of medication	For what condition?