Staying Strong at Home

Health Medical Activity Status Questionnaire

Fitness & Function LLC
www.FitnessAndFunction.com
Phone: 503-267-1030
Fax: 971-228-8638
Email: info@fitnessandfunction.com
4804 NW Bethany Blvd. Suite 12 #167
Portland, OR 97229

Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Home phone: _____ **Mobile phone:** _____
Email address: _____
Gender: **Male** ☐ **Female** ☐ **Date of birth:** _____ **Age:**_____
Weight: _____ **Height:** _____
Emergency contact: _____ **Relationship:** _____
Physician: _____ **Phone:** _____
Fax: _____

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	
Please list bone density T-Scores:			_____
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	_____

2. Have you ever been diagnosed as having any of the following conditions?

Cancer ☐Yes ☐No

If YES describe what kind: _____

_____

Joint replacement ☐Yes ☐No

If YES, how many times? _____

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

Cognitive disorder ☐Yes ☐No

If YES describe condition: _____

_____

_____

Uncorrected visual problems ☐Yes ☐No

If YES describe type: _____

_____

Any other type of health problem? ☐Yes ☐No

If YES describe condition: _____

_____

_____

3. Do you currently suffer any of the following symptoms in your legs or feet?

Numbness	☐Yes	☐No
Tingling	☐Yes	☐No
Arthritis	☐Yes	☐No
Swelling	☐Yes	☐No

4. Do you currently have any medical conditions for which you see a physician regularly?

Yes ☐ No ☐

If YES, please describe the conditions(s): _____

_____

_____

_____

5. Do you require eyeglasses? Yes ☐ No ☐

If YES, what type of glasses do you wear?

- ☐ Bi-Focals
- ☐ Graded Lenses
- ☐ Magnification Only
- ☐ Tri-Focals

6. Do you have your eyesight checked at least once a year? Yes ☐ No ☐

7. Do you require hearing aids? Yes ☐ No ☐

If yes, which ear? ☐Left ☐Right ☐Both

8. Do you use an assistive device for walking? ☐Yes ☐No ☐Sometimes

If YES or SOMETIMES, what type of assistive device do you use?

- ☐ Single-Point Cane
- ☐ 3-Point Cane
- ☐ Quad Cane
- ☐ Rolling Stand Walker
- ☐ 3-Wheel Walker w/Seat

9. List all medications that you currently take (including all "over-the-counter" and "alternative medicines")

Type of medication	*For what condition*

Please indicate your ability to do each of the following. (Place a ✓ in the most appropriate box.)	Can do	Can do with Difficulty or with help	Cannot do
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 1/2 mile (0.8 km, 6-7 blocks)	❑	❑	❑
i) Walk 1 mile (1.6 km, 12-14 blocks)	❑	❑	❑
j) Lift and carry 10 pounds (4.5 kg, e.g., a full bag of groceries)	❑	❑	❑
k) Lift and carry 25 pounds (11 kg, 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)	❑	❑	❑

10. Have you required emergency medical care or hospitalization in the past year? ☐Yes ☐No

If YES, please list when this occurred and briefly explain why.

_____

_____

11 Have you ever had any condition or suffered any injury that has affected your balance or ability to walk without assistance?

☐Yes ☐No

If YES, please list when this occurred and briefly explain condition or injury.

_____

_____

12. How many times have you fallen <u>within the past 6 months</u>? _____

If you have fallen in the past 6 months, please give a detailed description of the incident:

(a) Date: _____

(b) Location (i.e. indoors, outdoors): _____

(c) Reason for fall (i.e. uneven surface, going downstairs):

_____

_____

(d) Did you require medical treatment? ☐Yes ☐No

(e) Date: _____

(f) Location (i.e. indoors, outdoors): _____

(g) Reason for fall (i.e. uneven surface, going downstairs):

_____

_____

(h) Did you require medical treatment? ☐Yes ☐No

13. How concerned are you about falling?

☐1 - - - - - ☐ 2 - - - - - ☐3 - - - - -☐ 4 - - - - - ☐5 - - - - - ☐6 - - - - - ☐7
Not at all a little moderately very extremely

14. As a result of this concern, have you stopped doing some of the things you used to do or liked to do?

☐Yes ☐No

15. How would you describe your health (check)

☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

16. In the past 4 weeks, to what extent did health problems limit your everyday physical activities (such as walking and household chores)?

☐Not at all ☐Slightly ☐Moderately ☐Quite a bit ☐Extremely

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

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

18. In general, how much depression have you experienced in the past week?

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

19. In general, how would you rate the quality of your life?

☐1 - - - - - ☐ 2 - - - - - ☐3 - - - - -☐ 4 - - - - - ☐5 - - - - - ☐6 - - - - - ☐7
very low low moderate high very high

21. In general, do you currently require household or nursing assistance to carry out daily activities?

☐Yes ☐No If yes, please check the reasons(s)?

☐ Health problems
☐ Chronic pain
☐ Lack of strength or endurance
☐ Lack of flexibility or balance
☐ Other reasons: _____

22. In a typical week, how often do you leave your house? (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

23. Do you <u>currently</u> 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

24. 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

25. Did you require assistance in completing this form?

☐ None (or very little) ☐ Need quite a bit of help
Reason: _____

What is your wellness goal?

_____
_____
_____