

Health / Activity Information

FallProof™ Balance & Mobility Program

California State University, Fresno

Name: _____	
Address: _____	
City: _____	State: _____ Zip: _____
Home Phone #: () - _____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth: / / _____	Height: _____ Weight: _____
Ethnicity: _____	Highest level of education completed: _____
Whom to contact in case of emergency: _____	Phone #: () - _____
Name of your Physician _____	Phone #: () - _____
Years post menopause _____	Bone scan Score _____
Have you had a bone scan? ___Yes ___No	

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

Rheumatoid arthritis Yes No _____

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**If Yes
Year of Diagnoses**

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? Yes 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 require hearing aids?

Yes No

If yes, which ear?

Left Right Both

7. 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

8. List all medications that you currently take (including all “over-the-counter” and “alternative medicines”)

<i>Type of medication</i>	<i>For what condition</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

9. Have you required emergency medical care or hospitalization?

Yes No

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

10. 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.

11. How many times have you fallen within the past year? _____

If yes, please list 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

12. Are you worried about falling? (Check)

1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7
not a little moderately very extremely

13. How would you describe your health (check)

Excellent Very good Good Fair Poor

14. 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

15. 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

16. In general, how much depression have you experienced within the past 4 weeks?

Not at all Slightly Moderately Quite a bit Extremely

17. 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

18. Please indicate your ability to do each of the following (check appropriate response).

	Can Do	Can Do with difficulty or with help	Cannot Do
<p>a. Take care of own personal needs – like dressing yourself</p> <p>If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?</p> <p><input type="checkbox"/> Health problems</p> <p><input type="checkbox"/> Chronic pain</p> <p><input type="checkbox"/> Lack of strength or endurance</p> <p><input type="checkbox"/> Lack of flexibility or balance</p> <p><input type="checkbox"/> Other reasons: _____</p>	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
<p>b. Bathe yourself, using tub or shower</p> <p>If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?</p> <p><input type="checkbox"/> Health problems</p> <p><input type="checkbox"/> Chronic pain</p> <p><input type="checkbox"/> Lack of strength or endurance</p> <p><input type="checkbox"/> Lack of flexibility or balance</p> <p><input type="checkbox"/> Other reasons: _____</p>	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
<p>c. Climb up and down a flight of stairs (like to a second story in a house)</p> <p>If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?</p> <p><input type="checkbox"/> Health problems</p> <p><input type="checkbox"/> Chronic pain</p> <p><input type="checkbox"/> Lack of strength or endurance</p> <p><input type="checkbox"/> Lack of flexibility or balance</p> <p><input type="checkbox"/> Other reasons: _____</p>	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
<p>d. Walk outside one or two blocks</p> <p>If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?</p> <p><input type="checkbox"/> Health problems</p> <p><input type="checkbox"/> Chronic pain</p> <p><input type="checkbox"/> Lack of strength or endurance</p> <p><input type="checkbox"/> Lack of flexibility or balance</p> <p><input type="checkbox"/> Other reasons: _____</p>	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

	Can Do	Can Do with difficulty or with help	Cannot Do
e. Do light household activities – like cooking, dusting, washing dishes, sweeping a walkway	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
<p>If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?</p> <input type="checkbox"/> Health problems <input type="checkbox"/> Chronic pain <input type="checkbox"/> Lack of strength or endurance <input type="checkbox"/> Lack of flexibility or balance <input type="checkbox"/> Other reasons: _____			
f. Do own shopping for groceries or clothes	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
<p>If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?</p> <input type="checkbox"/> Health problems <input type="checkbox"/> Chronic pain <input type="checkbox"/> Lack of strength or endurance <input type="checkbox"/> Lack of flexibility or balance <input type="checkbox"/> Other reasons: _____			
g. Walk ½ mile (6-7 blocks)	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
<p>If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?</p> <input type="checkbox"/> Health problems <input type="checkbox"/> Chronic pain <input type="checkbox"/> Lack of strength or endurance <input type="checkbox"/> Lack of flexibility or balance <input type="checkbox"/> Other reasons: _____			
h. Walk 1 mile (12-14 blocks)	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
<p>If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?</p> <input type="checkbox"/> Health problems <input type="checkbox"/> Chronic pain <input type="checkbox"/> Lack of strength or endurance <input type="checkbox"/> Lack of flexibility or balance <input type="checkbox"/> Other reasons: _____			

	Can Do	Can Do with difficulty or with help	Cannot Do
i. Lift and carry 10 pounds (full bag of groceries)	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0

If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?

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

j. Lift and carry 25 pounds (medium to large suitcase)	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
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If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?

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

k. Do most heavy household chores – like scrubbing floors vacuuming, raking leaves	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
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If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?

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

1. Do strenuous activities – like hiking, digging in garden, moving heavy objects, bicycling, aerobic dance exercises, strenuous calisthenics, etc.

2

1

0

If you answered “Can Do with difficulty or with help” OR “Cannot Do”, why?

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

19. 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: _____

20. 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.)

- | | |
|--|---|
| <input type="checkbox"/> less than once/week | <input type="checkbox"/> 3-4 times/week |
| <input type="checkbox"/> 1-2 times/week | <input type="checkbox"/> most every day |

21. 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

22. 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

23. Did you require assistance in completing this form?

- None (or very little) Needed quite a bit of help Reason: _____

Thank You!