FallProof Health and Activity Questionnaire

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home phone # (_____) _____ Gender: Male ❑ Female ❑

Date of birth _____ Height _____ Weight _____

Person to contact in a case of emergency _____ Phone # (_____) _____

Name of your physician _____ Phone # (_____) _____

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	_____
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 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 conditions: _____

_____

_____

3. Do you currently experience 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, describe conditions: _____

_____

_____

(continued)

5. Do you require eyeglasses? ❑ Yes ❑ No

   If yes, what type of glasses do you wear?
   - ❑ Bifocals
   - ❑ Graded lenses
   - ❑ Magnification only
   - ❑ Trifocals

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
   - ❑ Three-point cane
   - ❑ Quad cane
   - ❑ Rolling stand walker
   - ❑ Three-wheel walker with seat

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

Type of Medication	For what condition?

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

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

11. Have you ever had any condition or experienced 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 *within the past 6 months*? _____

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 down stairs): _____

_____

_____

d. Did you require medical treatment? ❑ Yes ❑ No

e. Please provide some details for any additional fall you had in the past 6 months:

_____

_____

_____

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 overall health?

❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

16. 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

(continued)

17. 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	❑ 2	❑ 1	❑ 0
b. Bathe yourself, using tub or shower	❑ 2	❑ 1	❑ 0
c. Climb up and down a flight of stairs (e.g, second story)	❑ 2	❑ 1	❑ 0
d. Do light household activities (e.g., cooking, dusting, washing dishes, sweeping a walkway)	❑ 2	❑ 1	❑ 0
e. Do heavy household activities (e.g., scrubbing floors, vacuuming, raking leaves)	❑ 2	❑ 1	❑ 0
f. Do own shopping for groceries or clothes	❑ 2	❑ 1	❑ 0
g. Walk outside (one or two blocks)	❑ 2	❑ 1	❑ 0
h. Walk 1/2 mile (0.8 km, 6-7 blocks)	❑ 2	❑ 1	❑ 0
i. Walk 1 mile (1.6 km, 12-14 blocks)	❑ 2	❑ 1	❑ 0
j. Lift and carry 10 pounds (4.5 kg, e.g., a full bag of groceries)	❑ 2	❑ 1	❑ 0
k. Lift and carry 25 pounds (11 kg, e.g, medium to large suitcase)	❑ 2	❑ 1	❑ 0
l. Do strenuous activities (e.g., hiking, calisthenics, moving heavy objects, bicycling, aerobic dance activities, strenuous digging in garden)	❑ 2	❑ 1	❑ 0

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

❑ Yes ❑ No

If yes, please check the reasons.

❑ Health problems

❑ Chronic pain

❑ Lack of strength or endurance

❑ Lack of flexibility or balance

❑ Other reasons: _____

_____

_____

19. 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 ❑ 3-4 times

❑ 1-2 times ❑ almost every day

20. Do you *currently* participate in regular physical exercise (such as walking, sports, exercise classes, housework, 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

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

❑ Strolling (easy pace, takes 30 minutes 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

22. Did you require assistance in completing this form?

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

Reason: _____

_____

_____

_____

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