DATE:_____

Center for SUCCESSFUL AGING
HEALTH . VITALITY . WELL-BEING

fall PROOF

Health / Activity Information

California State University, Fullerton

Name: _____

Address: _____

City _____ *State:* _____ *Zip:* _____

Home Phone #: ( ) - _____ *Gender:* *Male* ☐ *Female* ☐

Cell Phone #: ( ) - _____ *E-mail:* _____

Date of Birth: __ / __ / __ *Height:* _____ *Weight:* _____

Ethnicity: _____ *Highest level of education completed:* _____

Whom to contact in case of emergency: _____ *Phone #:* ( ) - _____

Relationship of emergency contact: _____

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	
Continued from page 1			**If Yes Year of Diagnoses**
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 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*

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.

_____

_____

12a. 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

12b How many times have you fallen <u>within the past year</u>? _____

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

(c) Date: _____

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

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

_____

_____

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

(h) Date: _____

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

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

_____

_____

(i) 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. 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

e. Do you feel pretty worthless the way you are now? ☐Yes ☐No

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

20. 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	Can not do without help	Can not 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)	☐	☐	☐	☐	☐

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? (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

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) ☐ Needed quite a bit of help
Reason: _____

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

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