

**Form 3.1**

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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Other arthritic conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Visual/depth perception problems	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Inner ear problems/recurrent ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cerebellar problems (ataxia)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Other movement disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Chemical dependency (alcohol or drugs)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> 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

☐ Rolling stand walker

☐ Three-point cane

☐ Three-wheel walker with seat

☐ Quad cane

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

