SteadyFeet® Health Screening Form

Participant Information

Name_____ Date of Birth_____

Gender: male ☐ female ☐ Age_____ Phone # _____

Address _____

City_____ Postal code_____

Emergency contact _____Phone # _____

Doctor's name _____ Phone #_____

Referred by_____

How did you hear about this program? _____

Health Activity Questionnaire:

1. 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? ☐Y ☐N

a) Describe the exercise/activities: _____

_____

b) How many days per week do you exercise?_____

c) How many minutes per day do you exercise? _____?

3. Have you had a fall in the past 6 months? ☐Y ☐N If yes, how many? _____

Were you injured? If yes, please describe injuries _____

4. Have you had a hospital stay in the past 6 months? ☐Y ☐N
If yes, please give details on reason for admission and treatment received.

_____

_____

5. How many medications are you currently taking? _____

6. Has your doctor ever said that you have a heart condition and /or should only participate in medically supervised physical activity? ☐Y ☐N

7. Do you ever feel pain in your chest during physical activity? ☐Y ☐N

8. Have you experienced chest pains when not doing physical activity? ☐Y ☐N

9. Do you experience dizziness? ☐Y ☐N

10. Have you been told that you have high blood pressure? ☐Y ☐N

11. Have you ever had a stroke? TIA's (mini strokes) ☐Y ☐N

12. Have you been diagnosed with osteoporosis or osteopenia? ☐Y ☐N

13. Do you have arthritis? ☐Y ☐N
If yes, which joints are affected?

_____

Have you had any joints replaced? ☐Y ☐N Which ones? When?_____

_____

14. When was the last time you had your vision checked? _____

15. Have you been diagnosed with any eye conditions? ☐Y ☐N

16. Have you been diagnosed with any neurological condition (ie Parkinson's disease, Multiple sclerosis) ☐Y ☐N
If yes, please provide details _____

17. Do you have Diabetes? ☐Y ☐N

Do you take medications for diabetes? ☐Y ☐N

18. Do you have decreased sensation in your feet? ☐Y ☐N

19. Are you aware of any other reasons why you should not participate in physical exercise without medical supervision? ☐Y ☐N

If yes,what are the reasons?

_____

_____

_____

I understand that my assessment measures will be used by SteadyFeet® Program partners for the purpose of program improvement and quality assurance, and that my personal information will remain confidential.

Signed: _____ **Date:** _____