Annual Mobility Assessment Data Sheet

ID Number: ______________ Date: _________________________

Name: ________________________________ Age: ____ Sex ☐Male ☐Female

Blood pressure (mm Hg) _______ Heart Rate (bpm) ______ Oxygen Saturation (%) ________

Usual Gait Speed
Distance used (5 meters recommended) - _______

	Time (seconds)	**Gait Speed (meters/seconds)**
UGS Trial 1		
UGS Trial 2		
UGS Average		

Age and Sex Norms Average ________ SD __________ Red/Yellow/Green

Fast Gait Speed
Distance used (5 meters recommended) - _______

	Time (seconds)	**Gait Speed (meters/seconds)**
FGS Trial 1		
FGS Trial 2		
FGS Best		

Age and Sex Norms Average ________ SD __________ Red/Yellow/Green

30 Second Sit to Stand

	Number of Stands
30STS Trial 1	

Age and Sex Norms Average ________ SD __________ Red/Yellow/Green

Four Square Step Test
True or Modified Protocol – ☐True ☐Modified

	Time (seconds)
FSST Trial 1	
FSST Trial 2	
FSST Best	

Age and Sex Norms Average ________ SD __________ Red/Yellow/Green

Timed Up and Go

	Time (seconds)
TUG Trial 1	
TUG Trial 2	
TUG Best	

Age and Sex Norms   Average ________   SD __________   Red/Yellow/Green

Timed Up and Go - Cognitive

	Time (seconds)
TUG Cog Trial 1	

Age and Sex Norms   Average ________   SD __________   Red/Yellow/Green

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Recommendation Given to Participants

☐ No referral necessary

☐ Start exercises based on results

- ☐ Squats, sit to stand exercises
- ☐ Ankle strengthening
- ☐ Lunging exercises
- ☐ Upper extremity strengthening
- ☐ Static balance exercises
- ☐ Dynamic balance exercises
- ☐ Walking program
- ☐ Stair climbing
- ☐ Other ____

☐ Referral to a community-based program:

____

☐ Referral to physical therapy:

____

☐ Referral to another healthcare professional:

____

☐ Any additional concerns or issues found and actions taken ___________

____

Assessor's Name: ____

Assessor's Signature: ____