ID Number: _____

# Annual Mobility Assessment Intake Form

Date: _____

Name: _____ Age: _____

Sex at Birth: ☐Male ☐Female

Identified Gender: ☐Male ☐Female ☐Transgender ☐Trans-male ☐Trans-female ☐Non-binary ☐Prefer Not to Say

*These questions are about your overall health*

Weight (pounds): _____ Height (inches): _____

In general, would you say your health is: ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

In the last 12 months, has your health changed: ☐Much better ☐Somewhat better ☐Stayed the same ☐Somewhat worse ☐Much worse

Do you have any concerns about your mobility (ability to get around) or do things that you want to do? ☐Yes ☐No

If yes, what are your mobility concerns: _____

_____

*These questions are about your general physical activity levels*

In the last 12 months, have your physical activity levels changed?

☐More Active
☐About the Same
☐Less Active

For an average week in the last 30 days, how many days per week did you engage in moderate to vigorous physical activity (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?

_____ days

On those days that you engage in moderate to vigorous physical activity, on average, how many minutes per day do you engage in physical activity at this level?

_____ minutes

During the past month, how many days per week did you do physical activities or exercises to strengthen your muscles?

_____ days

On average, how many days per week do you perform activities that challenge your balance?

_____ days

*These questions are about your balance and recent history of falls*

Do you feel unsteady when standing or walking?

☐Yes
☐No

Do you worry about falling?

☐Yes
☐No

Have you fallen in the past year?

☐Yes
☐No

If yes, how many times? _____

If yes, were you injured?

☐Yes
☐No

*Think about your ability to perform the following activities and if you have changed the way you do the activity, decreased how often you do the activity, or if you are slower in completing the activity. Changing the way you do something means altering the method such as using a device or supporting yourself more on a surface.*

## Walking

| | |
|---|---|
| Do you have difficulty in walking more than a mile? | ☐No difficulty<br>☐Some difficulty<br>☐Great deal of difficulty<br>☐Only with the help of another<br>☐Unable, even with help |

**In the last 12 months….**

| | | |
|---|---|---|
| Have you changed the way you walk more than a mile? | ☐Yes | ☐No |
| Have you decreased how often you walk more than a mile? | ☐Yes | ☐No |
| Are you slower when you walk more than a mile? | ☐Yes | ☐No |
| Are you more tired or fatigued when you walk more than a mile? | ☐Yes | ☐No |

## Steps

Do you have difficulty in climbing a flight of steps?

☐No difficulty
☐Some difficulty
☐Great deal of difficulty
☐Only with the help of another
☐Unable, even with help

**In the last 12 months….**

| | | |
|---|---|---|
| Have you changed the way you climb a flight of steps? | ☐Yes | ☐No |
| Have you decreased how often you climb a flight of steps? | ☐Yes | ☐No |
| Are you slower when you climb a flight of steps? | ☐Yes | ☐No |
| Are you more tired or fatigued when you climb a flight of steps? | ☐Yes | ☐No |

## Getting On and Off the Floor

Do you have difficulty getting on and off the floor?

☐No difficulty
☐Some difficulty
☐Great deal of difficulty
☐Only with the help of another
☐Unable, even with help

**In the last 12 months….**

| | | |
|---|---|---|
| Have you changed the way you get on and off the floor? | ☐Yes | ☐No |
| Have you decreased how often you get on and off the floor? | ☐Yes | ☐No |
| Are you slower when you get on and off the floor? | ☐Yes | ☐No |
| Are you more tired or fatigued when you get on and off the floor? | ☐Yes | ☐No |

*These questions are about your health history*

**Check all of the conditions you have been diagnosed with:**

☐Heart conditions such as heart failure, heart attacks, or irregular heart beats

☐Breathing and lung conditions such as asthma, emphysema, or chronic obstructive pulmonary disease

☐Blood sugar and hormone conditions such as diabetes

☐Bone conditions such as osteoporosis

☐Joint conditions such as arthritis of any kind

☐Brain or nerve conditions such as stroke, seizures, Parkinson's disease, or multiple sclerosis

☐Cancer of any kind

☐Cognitive conditions such as mild cognitive impairments or dementia

☐Visual conditions such as glaucoma, cataracts, or macular degeneration

☐Hearing loss conditions

☐Conditions that affect balance such as vestibular issues or peripheral neuropathy

☐Incontinence conditions affecting bladder or bowels

**Check all of the procedures you've had in the past 12 months:**

☐Joint Replacement

☐Fractures

☐Cardiac related surgeries or procedures

☐Orthopedic related surgeries or procedures

☐Any other surgeries or procedures

☐Hospitalization for any other reason

☐None of the above

**END OF INTAKE FORM**

## For Assessor to Complete

Meeting Aerobic Guidelines? ☐Yes ☐No

Meeting Strengthening Guidelines? ☐Yes ☐No

Meeting Balance Guidelines? ☐Yes ☐No

Any Positive Response on STEADI? ☐Yes ☐No

Any self-reported mobility limitations? ☐Yes ☐No

Any self-reported preclinical mobility limitations? ☐Yes ☐No

Any concerning medical history or recent procedures? _____
_____

If participating in Repository, Repository number _____