

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: _____

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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

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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
- 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 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

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These questions are about your health history

Medications and Supplements

How many prescription medications do you take each day? _____

How many over the counter products, such as supplements or vitamins, do you take each day? _____

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

ID Number: _____

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 _____