

Participant ID: _____

Year of Initial Visit to CHAMP: _____

Height: [1st visit] _____ft _____in.

CHAMP Visit #	6	7	8	9	10
Risk Factor	Date:	Date:	Date:	Date:	Date:
ABC Scale score (<67%)	%	%	%	%	%
Weight	#	#	#	#	#
Blood Pressure and Pulse [Circle any pulse that is irregular]					
Sitting	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg	/ mm Hg
Pulse	bpm	bpm	bpm	bpm	bpm
Oxygen saturation	%	%	%	%	%
Dizziness with positional change?					
Medication Concerns					
Any medication changes or other medication concerns?					
Vision Concerns					
Date of last eye exam _____ Any new concerns about vision?					
Balance Concerns Four Stage Balance Test - record times to nearest 0.1 sec					
Feet together to 10 sec max	_____ sec	_____ sec	_____ sec	_____ sec	_____ sec
Semi-tandem to 10 sec max	_____ sec	_____ sec	_____ sec	_____ sec	_____ sec
Tandem to 10 sec max	_____ sec	_____ sec	_____ sec	_____ sec	_____ sec
*At risk if less than 6.5 sec. One leg stand to 30 sec max	_____ sec	_____ sec	_____ sec	_____ sec	_____ sec
Strength Concerns					
Grip Strength in lbs. (mean of 3 trials) - optional after 1 st visit	R:	R:	R:	R:	R:
	R:	R:	R:	R:	R:
	R:	R:	R:	R:	R:
	Mean:	Mean:	Mean:	Mean:	Mean:
	L:	L:	L:	L:	L:
	L:	L:	L:	L:	L:
	L:	L:	L:	L:	L:
Mean:	Mean:	Mean:	Mean:	Mean:	
Chair Stands	Number completed in 30 sec				
	Modification needed? Describe, and enter number of stands				

Participant ID: _____

CHAMP Visit #	6	7	8	9	10
Risk Factor	Date:	Date:	Date:	Date:	Date:
Mobility Concerns					
Timed Up and Go (TUG) [allow 1 practice trial, then 2 test trials]	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:	1: 2: MEAN:
Instability during TUG?					
*Risk of Fall? (mean \geq 12 sec, or instability noted)					
List any assistive device(s)					
Is participant wearing appropriate footwear? Difficulty purchasing?					
Follow Up					
Since your most recent visit to CHAMP, rate your performance in following exercise recommendations: <small>1 Poor 2 Borderline 3 Satisfactory 4 Good 5 Outstanding</small>					
In the past 7 days, how many days have you done your exercises? (0-7)					
Have you had a fall since your most recent visit to CHAMP? How many? Were you hurt? Did you call EMS or go to the hospital Emergency Department? Other information?	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N	# Falls ____ Injury Y/N EMS, ED Y/N

VISIT #6 Date:

Summary of today's assessment:

Return date: _____

Check here if exercises were given.

Screener signatures: _____

Check here if exercises were modified.

Check here if falls/exercise calendar was reviewed.

VISIT #7 Date:

Summary of today's assessment:

Return date: _____

Check here if exercises were given.

Screener signatures: _____

Check here if exercises were modified.

Check here if falls/exercise calendar was reviewed.

Participant ID: _____

Visit #8 Date:

Summary of today's assessment:

Return date: _____

Check here if exercises were given.

Screener signatures: _____

Check here if exercises were modified.

Check here if falls/exercise calendar was reviewed.

Visit #9 Date:

Summary of today's assessment:

Return date: _____

Check here if exercises were given.

Screener signatures: _____

Check here if exercises were modified.

Check here if falls/exercise calendar was reviewed.

Visit #10 Date:

Summary of today's assessment:

Return date: _____

Check here if exercises were given.

Screener signatures: _____

Check here if exercises were modified.

Check here if falls/exercise calendar was reviewed.