CHAMP The Community Health and Mobility Partnership

PARTICIPANT INFORMATION

Please print your responses and complete all 3 pages. Thank you.

Have you participated in past CHAMP screenings? ☐ YES ☐ NO

1. Name_____
2. Gender: ☐ Male ☐ Female
3. Phone Number_____
4. Address_____
5. Birth date____/____/____
6. Age_____
7. Height_____
8. Weight_____
9. Ethnicity: Do you consider yourself to be Hispanic or Latino? (See definition below.) Select one.

Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

☐ **Hispanic or Latino**

☐ **Not Hispanic or Latino**

10. Race: What race do you consider yourself to be? Select one or more of the following.

☐ ***American Indian or Alaska Native.*** A person having origins in any of the original peoples of North, Central, **or** South America, and who maintains tribal affiliation or community attachment.

☐ ***Asian.*** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian **subcontinent**, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ ***Black or African American.*** A person having origins in any of the black racial groups of Africa.

☐ ***Native Hawaiian or Other Pacific Islander.*** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or **other** Pacific Islands.

☐ ***White.*** A **person** having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ Check here if you do not wish to provide some or all of the above information.

11. What is the highest degree you obtained? (check one)

☐ Less than a high school diploma or GED

☐ High school diploma or GED

☐ Associate degree

☐ Bachelor's degree

☐ Graduate degree

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12. Have you ever had any of the following conditions? (check all that apply)

☐ Heart attack Date:	☐ Cancer Type:_____ When: _____ Any current treatment : _____
☐ Heart Disease	☐ Osteoporosis
☐ High Blood Pressure	☐ Fracture (broken bone) Which bone? _____ When: _____ Treatment: _____
☐ Chest pain	☐ Stroke When?_____ Which side? _____
☐ Arthritis Where? _____	☐ Neurologic conditions, such as Parkinson's Disease
☐ Foot disorders or pain (e.g. bunions, heel spur)	☐ Fainting spells
☐ Problem with vision that is not corrected by glasses	☐ Feeling blue or depressed
☐ Diabetes (high sugar)	☐ Difficulty sleeping
☐ Neuropathy (numbness in hands or feet)	☐ Incontinence (bladder or bowel) or bladder leaking
☐ Dizziness	☐ Shortness of breath When walking or exercising _____ At rest _____
☐ Other: Please specify	

13. Do you live: (check one)

☐ Alone without assistance

☐ With a spouse, other relative, or friend

☐ Alone in your own residence, with assistance from a friend, housekeeper, or personal aide

14. Do you have an emergency call device (e.g., Lifeline)? ☐ YES ☐ NO

15. Do you go up/down any steps to enter your home? ☐ YES ☐ NO
If yes, is there a handrail? ☐ YES ☐ NO

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16. Do you go up/down any steps once you are inside your home? ☐ YES ☐ NO
    If yes, is there a handrail? ☐ YES ☐ NO

17. Do you use any devices for safety or to assist you in the bathroom ☐ YES ☐ NO
    If yes, please specify:
    ☐ grab bar(s) ☐ raised toilet seat
    ☐ shower or tub chair ☐ long-handled sponge
    ☐ other (specify: _____)

18. Have you experienced a fall (defined as unintentionally coming to rest on the ground or other lower surface) over the past 12 months? ☐ YES ☐ NO

    If yes, how many falls? _____

    How many of these falls resulted in injury? _____

    How many of these falls with injury required evaluation by a physician? _____

    Nature of any injuries? _____

19. Do you limit your activities because you are afraid you might fall? ☐ YES ☐ NO

    Rate your fear of falling on a 0 – 10 scale, with 10 being greatest fear _____

20. Do you wear sturdy walking shoes with low or no heels? ☐ YES ☐ NO

21. Do you have difficulty purchasing shoes that are good quality and fit you well? ☐ YES ☐ NO

The following questions refer to how you are feeling TODAY

22. Do you have any pain today? ☐ YES ☐ NO
    If YES, where? _____ Is your pain increased by physical activity? ☐ YES ☐ NO

    Rate your pain on a 0 – 10 scale, with 10 being worst pain _____
    _____

23. Have you had any signs of problems with your blood pressure today (such as dizziness or headache)? ☐ YES ☐ NO
    If YES, please describe.

24. Have you had any signs of problems with your blood sugar today? ☐ YES ☐ NO
    If YES, please describe.

25. Have you had any surgical or medical procedures in the past 6 months? ☐ YES ☐ NO
    If YES, please describe.

26. Do you have any concerns that you may not be able to participate in the testing today?