



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. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or African American."

☐

**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)

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