Health History

Date (MM/DD/YYYY) ____________

Name (please print) _________________________________ DOB (MM/DD/YYYY) ___________________

Check any of the following that apply to your health (currently or in the past): The information you provide will help us develop an individualized plan to help you meet your goals.

- ☐ Heart Condition - if yes specify
  ____
- ☐ High Blood Pressure or on Blood Pressure Medicine
- ☐ Cardiac Surgery - if yes, what kind and when
  ____
- ☐ Pain in your chest while DOING physical activity
- ☐ Pain in your chest while NOT DOING physical activity
- ☐ Diabetes Hypoglycemia (low blood sugar

Respiratory Disease (check all that apply)

- ☐ Chronic Bronchitis ☐ Asthma ☐ Emphysema
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke – when and how affected
- ☐ Arthritis (Type: ☐ Osteo ☐ Rheumatoid)
- ☐ Ankylosing Spondylitis
- ☐ Post-Polio Syndrome
- ☐ Muscular Dystrophy
- ☐ Ataxia
- ☐ Morbid Obesity
- ☐ Spinal Muscular Atrophy
- ☐ Neuropathy
- ☐ Lymphedema
- ☐ Osteogenesis Imperfecta
- ☐ Cerebral Palsy
- ☐ Spina Bifida
- ☐ Epilepsy or Seizure Disorder
- ☐ Head Injury date of onset ________________
- ☐ Shunt where______________ date _________
- ☐ Any other chronic medical condition
  ____
- ☐ Orthopedic Surgery – type and date
  ____
- ☐ Any bone or joint problems that limit you from engaging in physical activity – if yes specify
  ____
- ☐ Currently Pregnant
- ☐ Chronic Dizziness

- ☐ Amputation - Type ______________________
  Prosthesis ☐ Yes ☐ No
- ☐ Spinal Cord Injury (date of onset)___________
  ☐ Paraplegia ☐ Quadriplegia
- ☐ Blind or Low Vision
- ☐ Requires assistance with community mobility
  ☐ Yes ☐ No

- ☐ Incontinence of bowel or bladder
- ☐ On a bowel management program
- ☐ History of gastrointestinal (GI) issues such as irritable bowel syndrome (IBS), C-diff, Crohn's, Colitis, etc.
- ☐ Current pressure sore(s)
  where ________________________________
- ☐ Current open wound(s)
  where ________________________________
- ☐ Seizure in the past 6 months
  date ___________________

Will a caregiver or family member be attending with you? ☐ Yes ☐ No

Do you use a mobility device to get around inside the home or in the community? ☐ Yes ☐ No

☐ Manual Wheelchair ☐ Power Wheelchair ☐ Walker/Rollator ☐ Cane/Crutches ☐ Other ____________

List any information you would want shared with emergency personnel, including medications and allergies.

____

LAKESHORE

Functional Ability Classification Questions

Name: ______________________________

Vision

Do you have difficulty seeing, even if wearing glasses?

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all
- ☐ Prefer not to say
- ☐ Don’t know

Hearing

Do you have difficulty hearing, even if using a hearing aid(s)?

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all
- ☐ Prefer not to say
- ☐ Don’t know

Mobility

Do you have difficulty walking or climbing steps?

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all
- ☐ Prefer not to say
- ☐ Don’t know

Cognition (Remembering)

Do you have difficulty remembering or concentrating?

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all
- ☐ Prefer not to say
- ☐ Don’t know

Self-care

Do you have difficulty with self-care, such as washing all over or dressing?

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all
- ☐ Prefer not to say
- ☐ Don’t know

Communication

Using your usual language, do you have difficulty communicating, for example understanding or being understood?

- ☐ No difficulty
- ☐ Some difficulty
- ☐ A lot of difficulty
- ☐ Cannot do at all
- ☐ Prefer not to say
- ☐ Don’t know