Reach
EXERCISE PHYSIOLOGY

BLACKWOOD COMMUNITY RECREATION CENTRE

Blackwood Community Recreation Centre – No Falls Program Assessment

Name: ______________________________ DOB: ____ /____ /_______

Phone: ______________________________

Address: ____

Emergency Contact Name: __________________________ Number: ______________________

Details of GP and Clinic: ____

____

Medical History:

Do you have a heart condition? e.g. Angina, cardiovascular disease	☐ Yes	☐ No
Do you have a neurological condition? e.g. stroke, parkinsons, MS, MND	☐ Yes	☐ No
Do you have high or low blood pressure which is not managed?	☐ Yes	☐ No
Do you have diabetes which is unstable?	☐ Yes	☐ No
Do you have a respiratory condition? e.g. asthma, emphysema, COPD	☐ Yes	☐ No
Are you over age 65 and been completely inactive for the last 2 years?	☐ Yes	☐ No
Have you ever had cancer requiring chemotherapy or radiotherapy?	☐ Yes	☐ No
Have you ever been diagnosed with osteoporosis?	☐ Yes	☐ No

CONTRAINDICATIONS – if you have any of the below conditions this program is not appropriate.

- Acute myocardial infarction or recent unstable angina (chest pain or recent heart attack).
- Uncontrolled atrial or ventricular arrhythmias. (eg Atrial Fibrillation).
- Dissecting aortic aneurysm.
- Severe aortic stenosis.
- Endocarditis / acute pericarditis.
- Uncontrolled high blood pressure.
- Acute thromboembolic disease.
- Acute or severe heart failure.
- Acute or severe respiratory failure.
- Uncontrolled postural hypotension.
- Uncontrolled diabetes mellitus (Type 2 Diabetes) or uncontrolled low blood sugar.
- A fracture in the last month
- Any other circumstance that you would consider prevents you from performing physical activity

Please list all other medical conditions including any regular joint pain:

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Medications:

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Falls History:

Please circle the following as appropriate:

Fall in the last: 12months 6 months 3 months 1 month

Do you use mobility aids: Yes / No

If "Yes" please state which aids:____

Do you experience dizziness: Yes / No

Do you experience regular tripping: Yes / No

Are you fearful of falling: Yes / No

Do you have issues with vision eg poor peripheral vision: Yes / No

If "Yes" please comment:____

Do you have any numbness or loss of sensation in your feet: Yes / No

Please comment on the frequency of your falls, your ability to get up from the floor and what injuries have occurred as a result of your falls.

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What is your balance like?
Please comment on what activities you find difficult due to your balance.

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Are you able to complete your normal Activities of Daily Living?
Eg. Dressing yourself, cleaning dishes, hanging our washing etc.
Make comments on anything you find difficult.

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Do you do any exercises currently? Yes / No

If Yes, what exercises are you currently doing?

____

____

What are your Physical Activity and Balance Goals?

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Objective Assessments: *Best of 3 - Average of 3

Test	**Pre program**	**Comments/normative data comparison**	**Post program**	**Comments**	**Comparison to Norms – tick if <u>above</u> high falls risk norms**
Timed 5 reps sit to stand		*(less than 12s)*			☐
Grip strength	**1 2** **L)** **R)**	*(less than 27kg for M)* *(less than 16kg for F)*	**1 2** **L)** **R)**		☐
Timed up and go (3m) – *use normal walking aids*	**L)** **R)**	*(less than 12s)*	**L)** **R)**		☐
Gait Speed		*>5s or 0.7m/s*			☐
Timed feet together + Eyes Closed		*<10s*			☐
Timed tandem stance – *indicated foot forward*	**L)** **R)**	*<10s* *(stepping reflex?)*	**L)** **R)**		☐
Timed single leg stance	**L)** **R)**	*<10s*	**L)** **R)**		☐
Functional Reach: Seated OR Standing – *(circle)*		*(circle – repeat same for follow up)* *Seated / Standing* *<15cm*			☐

Exercise Physiologist assessment and observations (walking gait patterns, sitting posture, standing posture, weight transfer, stepping over objects, walking and turning head, stair climbing, etc.)

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Overall assessment, falls risk, EP Recommendations:

____

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____

Recommended Tier: **Beginner** | **Intermediate** | **Advanced**

Exercise Physiologist Name: ____

Signature: ____ **Date:**______/_______/_______

<u>Summary of program outcomes/post assessment:</u>

____

____

____

Exercise Physiologist Name: ____

Signature: ____ **Date:**______/_______/_______

Participant feedback post program:

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