nova scotia health
Community Health Team

**Physical Activity Screen**

**Date:**

| **Full Name on Health Card:** | |
|---|---|
| **Health Card #** | **Phone #** |
| **Birth Date:** | |

**Which program are you looking to register for? Date:** **Location:**

☐Ready, Set, Move ☐ Low Intensity Exercise Program ☐ other:_____
☐Move to Improve ☐ Building Better Balance ☐ Balance Basics (2 wk)

Have you participated in this program before? ☐ Yes ☐ No Approx.date

**Please check conditions that you have**

| | |
|---|---|
| ☐ Kidney Disease<br>☐ Osteoporosis (thinning of bones)<br>☐ Pain in calves when walking<br>☐ Swelling in both feet that's worse at night<br>☐ Dizziness, fainting, or blackouts? | ☐ Aneurysm (either yourself or a close relative)<br>☐ Connective tissue disease<br>☐ Stroke: If yes, when? _____<br>☐ Arthritis: If yes, which joints? _____<br>_____ |

**Please answer all the questions below**

| **Do you have:** | **Do you have:** | **Have you had:** |
|---|---|---|
| Shortness of breath ☐Yes ☐No<br>COPD ☐Yes ☐ No<br>Do you use puffers ☐Yes ☐ No<br>If so, for what_____ | Diabetes ☐Yes ☐ No<br>If yes, do you regularly have blood sugars below 4 or above 11? ☐Yes ☐ No | Cancer ☐Yes ☐ No<br>If yes, have you received treatment within the last three months? ☐Yes ☐ No |

| | |
|---|---|
| Have you ever seen a health care provider because of your heart?<br>☐Yes ☐ No If yes ⟶ | Please check off any that apply:<br>☐ Heart murmur ☐ Heart Palpitations<br>☐ Heart Attack ☐ Other _____<br>☐ Heart Surgery _____ |

**Do you have:**

Angina (chest pain/tightness) ☐Yes ☐ No If yes ⟶ Do you carry nitroglycerin with you? ☐Yes ☐ No

High blood pressure ☐Yes ☐ No If yes ⟶ Is it controlled with medication? ☐Yes ☐ No

**Please answer the questions below regarding walking and balance**

| | | |
|---|---|---|
| Do you use a mobility aid, such as a cane or walker?<br>☐Yes ☐ No Type:_____ | Can you get out of a chair without using your hands?<br>☐ Yes ☐ No | Can you stand alone without holding onto anything?<br>☐ Yes ☐ No |

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| How long can you walk without needing to stop and take a rest?<br>0-5 min ☐ 5-10 min ☐ 10-15 min ☐ 15-20 min ☐ more than 30 min ☐ | | |
|---|---|---|
| Do you have poor balance or a Fear of Falling?<br>☐Yes ☐ No | Have you fallen in the past year? ☐Yes ☐ No<br>If yes, how many times_____ | Have you fallen in the past month?<br>☐Yes ☐ No |

Is there anything else that you would like to tell us about your health history?

_____

_____

_____

One of our health care providers will review this form to determine if you are appropriate for one of our programs. An individual assessment, with the physiotherapist, may be booked if you meet the criteria for the Low Intensity Exercise Program or Building Better Balance.

Please complete the following:

- ☐ I give the Community Health Team permission to contact me for more information by phone, email, and/or leave a message.
- ☐ I give the Community Health Team permission to obtain information from my family practice provider if needed.

Email address: _____

**PT USE ONLY**

**Date received:** _____

**Date contacted:** _____

**Client Appropriate for:**
☐ RSM ☐ LIEP ☐ MTI ☐ BBB
☐ Other:_____

**Comments:**_____
_____
_____
_____

**For "Move To Improve" program only:**

Do you have a chronic condition? ☐Yes ☐ No _____

**Physical Activity Vital Sign**

Do you participate in any type of moderate to vigorous physical activity?

☐Yes ☐ No

If yes, how many times a week do you do this and for how many minutes?

_____days x _____minutes =_____ total