QUESTIONNAIRE

Date questionnaire completed: _____/___/_____
mm/dd/yyyy

Name: _____
Last First

Address: _____ Postal Code: _____

Home Phone: (___)_____ Work Phone: (___)_____ Cell Phone: (___)_____

Email Address: _____ Date of Birth: _____/___/____
Prefer to be contacted by: _____ mm/dd/yyyy
How did you hear about Osteo-Circuit? _____

What are your reasons for joining the Osteo-Circuit?

a. _____
b. _____
c. _____

Family Doctor: _____ Specialist: _____
Emergency Contact: _____ Phone Number: _____
Assessment Fee: _____
Consent for Assessment: _____

OsteoCircuit
Building Better Bones

Name: _____

PART A: Medical History

1. Has a doctor ever told you that you have one of the following conditions? (Please check all that apply)

	Yes
Osteoporosis	
Low Bone Density	
Rheumatoid arthritis	
Osteoarthritis	
Heart disease	
Hypertension	
Hypotension	
Stroke	
TIA (transient ischemic attack)	
Pacemaker	
Diabetes: (if yes please circle the type) 1 = Insulin Dependent 2 = Non-Insulin Dependent Age of onset _____	
Asthma or other breathing problem	
Epilepsy	
Joint replacement	
Balance disorder or dizziness	
Orthostatic intolerance – decrease in blood pressure with change of position	
Cancer (if yes, please fill in the following): Type _____ Location _____ Treatment _____	
Women: Are you pre or post-menopausal	
Other	

2. Date of most recent Bone Mineral Density test: _____/___/_____
   mm/dd/yyyy

3. (Please circle) Compared to your last test, the bone density

For BACK:	Has **Increased**	Stayed the **Same**	Has **Decreased**	I'm **Not Sure**
For HIP:	Has **Increased**	Stayed the **Same**	Has **Decreased**	I'm **Not Sure**

4. What was your **greatest** height as a young adult? _____ ft. _____ in.

5. Do you personally have a history of any ***other*** significant illness (besides those previously listed)? Yes ☐ No ☐
   If yes, please describe on the two lines below:
   _____
   _____

Name: _____

6. Have you had any surgery? Yes □ No □
   If yes, please print the type of surgery you had.
   _____
   _____
   a. Does the surgery limit your mobility to ability to be physically active?
      Yes □ No □
7. In general, would you say your health is:

□Excellent □Very Good □Good □Fair □Poor

8. **Compared to one year ago**, how would you rate your health in general now?

□Much better □Somewhat better □About the same □Somewhat worse □Much worse

PART B: Medication and Supplements

1. List all current medications taken.

MEDICATIONS	
Name	Purpose

2. List all current vitamins or supplements (including minerals, herbal remedies, etc.) taken.

Vitamins and Supplements	
Name	Purpose

PART C: Lifestyle

1. ALCOHOL:
   Do you drink alcohol? Yes □ No □
   If yes (check one): □ 0-2/day □ >2/day
2. CAFFEINE:
   Do you drink caffeinated beverages (e.g. coffee)? Yes □ No □
   If yes (check one): □ 0-2/day □ >2/day
3. TOBACCO
   Have you ever used any of the following products (presently or in the past) on a daily basis for a period of at least 6 months?

Cigarettes	□ Yes	□ No
Pipes	□ Yes	□ No
Cigars	□ Yes	□ No

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Name: _____

PART D: Work, Physical Activity and Exercise

1. Presently working? Yes □ No □ _____
2. Do you presently do 150 minutes of aerobic activity per week? Yes / No
3. Do you presently do muscle strengthening 2 times per week? Yes / No
4. Present physical activity, exercises and hobbies:
   _____
   _____
   _____
   _____
5. Do you currently have any pain that limits physical activity?

Locations	Pain (Mark if present)
Neck	□ Yes
Shoulders	□ Yes
Back	□ Yes
Hips	□ Yes
Knees	□ Yes
Other	□ Yes

6. Do you use medication for pain at least once a week? Yes □ No □

PART E: Fall(s) History

1. Have you fallen in the past year? Yes □ No □
   If yes, how many times? _____ Why? _____
2. How often do you feel dizzy or unbalanced during standing or walking?
   - □ Never
   - □ Rarely
   - □ Sometimes
   - □ Always
3. Do you have trouble:

Reaching overhead?	Yes □	No □
Picking up objects from the floor?	Yes □	No □
Getting in and out of the bathtub?	Yes □	No □
Walking without holding onto something?	Yes □	No □
Climbing stairs?	Yes □	No □

4. How true or false is this statement? I am afraid of falling.

□Definitely True □Mostly True □Don't Know □Mostly False □Definitely False

Name: _____

PART F: Fracture History

1. In the past year, have you fractured or broken any bones? Yes ☐ No ☐
   How many times have you fractured a bone in the past year? _____

2. If you have broken a bone, please list which bones, what year, whether an X-ray was taken, and how it happened (please use the chart below).

Which bone(s)?	Year	X-ray taken? (yes/no)	How did it happen?