SENIOR HOME CONNECTION

By Play Move Improve — Robyn Papworth, ESSA Registered Exercise Physiologist

Telehealth Pre-Program Questionnaire

Health, mobility & home safety intake — to be completed before your telehealth consultation

Please complete this questionnaire as thoroughly and honestly as you can, either yourself or with the help of a family member, carer, or support worker. There are no right or wrong answers — this simply helps Robyn understand your current health, balance, confidence and home environment so she can select movements from the Never Too Old to Play program that are safe and appropriate for you, and identify where a support person should be present. If any question is unclear, leave it blank and we will go through it together during your telehealth session.

1. Personal & Emergency Contact Details

Full name

Date of birth

Home address

Phone number

Email address

Preferred contact method

Emergency contact

Name & relationship

Phone number

Your doctor (GP)

GP name & clinic

Clinic phone number

Who will be with you (in person or nearby) during your telehealth session, if anyone?

2. Health & Medical History

Have you been diagnosed with any of the following?

- ☐ Heart disease
- ☐ Stroke or TIA (mini-stroke)
- ☐ Diabetes
- ☐ Arthritis
- ☐ Previous fracture(s)
- ☐ Cancer (current or past)
- ☐ High or low blood pressure
- ☐ Parkinson's disease
- ☐ Osteoporosis or osteopenia
- ☐ Vertigo or inner ear / vestibular disorder
- ☐ Other neurological condition
- ☐ Respiratory condition (e.g. COPD, asthma)

If you ticked any of the above, please give brief details (when diagnosed, how it affects you):

Have you had any surgery in the last 12 months?

☐ Yes ☐ No

If yes, what and when:

Current medications

Please list all medications you currently take, including over-the-counter and vitamins/supplements.

Medication name	Dose / frequency	What is it for?	Causes dizziness or drowsiness?
			☐ Yes ☐ No ☐ Unsure
			☐ Yes ☐ No ☐ Unsure
			☐ Yes ☐ No ☐ Unsure
			☐ Yes ☐ No ☐ Unsure
			☐ Yes ☐ No ☐ Unsure

Do you currently use a mobility aid (cane, walker, wheelchair)?

☐ Yes ☐ No

If yes, which one, and how often (always / sometimes / outdoors only):

3. Falls History

Have you had a fall in the past 12 months?

☐ Yes ☐ No

If yes, how many times, and what happened (where, why, any injury):

Do you ever feel unsteady when standing up from a chair, walking, or turning around?

☐ Yes ☐ No

Please describe when this happens:

Confidence doing everyday activities

For each activity, please tick the box that best describes how concerned you are about falling.

Activity	Not at all concerned	Somewhat concerned	Fairly concerned	Very concerned
Getting dressed or undressed	☐	☐	☐	☐
Taking a bath or shower	☐	☐	☐	☐
Getting in/out of a chair	☐	☐	☐	☐
Walking around the house	☐	☐	☐	☐
Reaching into cupboards or shelves	☐	☐	☐	☐
Walking outside on uneven ground	☐	☐	☐	☐
Going up or down stairs	☐	☐	☐	☐
Walking in a busy or crowded place	☐	☐	☐	☐

4. Dizziness & Balance (Vestibular) Screening

This program includes exercises that involve head and eye movement, so this section is important.

Do you ever experience dizziness, vertigo (spinning sensation), or light-headedness?

☐ Yes ☐ No

How often, and how long does it last:

Is dizziness brought on by moving your head, changing position, or standing up quickly?

☐ Yes ☐ No

Please describe:

Have you been diagnosed with an inner ear condition (e.g. BPPV, Ménière's disease, vestibular neuritis)?

☐ Yes ☐ No

Details:

Do you feel more unsteady with your eyes closed, or in a dark room?

☐ Yes ☐ No

Have you ever fainted, blacked out, or felt you might faint?

☐ Yes ☐ No

Details:

5. Pain & Physical Limitations

Please indicate any areas of current pain, stiffness or swelling.

Area	Present?	Pain 0–10 (0=none,10=worst)	Worse with	Better with
Neck	☐ Yes ☐ No			
Shoulder(s)	☐ Yes ☐ No			
Upper back	☐ Yes ☐ No			
Lower back	☐ Yes ☐ No			
Hip	☐ Yes ☐ No			
Knee(s)	☐ Yes ☐ No			
Ankle / foot	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

Is there any movement, position, or activity you currently avoid because of pain or fear of injury?

6. Mobility & Current Activity Level

Can you stand unsupported for at least 1–2 minutes?

☐ Yes ☐ No

Can you walk without any aid or assistance?

☐ Yes ☐ No

If no, how far can you walk, and with what support:

Can you get up from a chair without using your hands or arms to push up?

☐ Yes ☐ No

Can you manage stairs?

☐ Yes ☐ No

With or without a rail:

Do you currently do any regular exercise or physical activity?

☐ Yes ☐ No

What, and how often:

7. Vision & Hearing

Do you wear glasses or contact lenses?

☐ Yes ☐ No

For distance / reading / both:

Have you been diagnosed with cataracts, macular degeneration, glaucoma, or another eye condition?

☐ Yes ☐ No

Details:

When was your last eye test?

☐ Yes ☐ No

Do you use a hearing aid, or have difficulty hearing instructions clearly?

☐ Yes ☐ No

8. Memory, Concentration & Safety Awareness

Do you have any difficulties with memory or concentration?

☐ Yes ☐ No

Please describe:

Have you been diagnosed with a cognitive condition (e.g. dementia, mild cognitive impairment)?

☐ Yes ☐ No

Details:

Are you comfortable following spoken instructions and completing an exercise independently once shown?

☐ Yes ☐ No

9. Home Environment & Support

Who do you live with (if anyone)?

Is another person usually available at home to supervise or assist with exercises?

☐ Yes ☐ No

Who, and what times of day are they available:

Do you have a sturdy kitchen bench, table, or chair you can hold onto for support?

☐ Yes ☐ No

Is your main floor space clear of rugs, cords, or clutter you could trip on?

☐ Yes ☐ No

Is the area you'd exercise in well lit?

☐ Yes ☐ No

Do you have basic household props available (soft ball, playing cards, towel, sturdy chair)?

☐ Yes ☐ No

Do you have a device (tablet, computer, or smartphone) and reliable internet for a video telehealth call?

☐ Yes ☐ No

10. Your Goals

What would you most like to improve or feel more confident doing?

Is there an activity you've stopped doing that you'd like to return to?

Anything else you'd like Robyn to know before your session?

11. Consent & Declaration

I confirm that the information provided in this questionnaire is accurate and complete to the best of my knowledge. I understand that this questionnaire, and the telehealth consultation that follows, are used to select exercises appropriate to my current health and abilities, and do not replace advice from my doctor. I understand I should stop any exercise and seek medical attention if I experience chest pain, severe dizziness, shortness of breath, or a fall.

Has your GP cleared you for exercise, or do you need to check with them before starting?

☐ Yes ☐ No

Notes:

Signature (or name if completed on your behalf) Date

Completed by (if not the participant) — name & relationship: