AMERICAN COLLEGE OF Lifestyle Medicine

LOMA LINDA UNIVERSITY HEALTH
Produced in collaboration with Loma Linda University

Please complete this form at least one week in advance of your appointment and either:
1) Send through your Patient Portal, or
2) Fax to 910-444-2337

Physical Activity Assessment

GETTING STARTED

		Very poor health										Excellent health
a.	Please circle your current overall **LEVEL OF HEALTH**.	0	1	2	3	4	5	6	7	8	9	10

b. Please rank the top **3 areas** you would like to improve with 1 being the most important and 3 the least important.

Sleep _____ Weight Management _____ Nutrition _____

Exercise _____ Purpose & Connection _____ Mental Health _____

Substance Use _____

		Not important at all										Very important
c.	How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
d.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
e.	How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
f.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
g.	How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10
h.	How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address?	0	1	2	3	4	5	6	7	8	9	10

i. **What would you like to gain from this lifestyle visit?** *Check all that apply*

☐ More medical/scientific knowledge ☐ Practical health tips ☐ Other: _____

☐ Accountability ☐ Personalized plan

Patient Name:_____ DOB: _____

EXERCISE

EXERCISE HABITS: AEROBIC/CARDIO TRAINING

a. During the average week, how many **days** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough to break a light sweat)? _____days

b. During an average session, how many **minutes** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough movement to break a light sweat)? _____min

_____ total min/week (days x min)

c. List types of aerobic activities you do (i.e. walking, jogging, swimming, bicycling, dancing, etc.): _____

_____

EXERCISE HABITS: STRENGTH/RESISTANCE TRAINING

a. During the average week, how many **days** do you do strength/resistance training? _____days

b. How many **minutes** do you exercise with strength/resistance training? _____min

_____ total min/week (days x min)

c. List types of activities you do (i.e. weightlifting, Pilates, kettle ball, resistance machines, exercise bands, etc.):____

_____

What MOTIVATES you *or would motivate you* to exercise? *Check top three*

- ❑ Nothing would motivate me
- ❑ Control Blood glucose
- ❑ Decrease stress
- ❑ Increase self-esteem
- ❑ Family or partner
- ❑ Body Image
- ❑ Prevent heart disease
- ❑ Other:_____
- ❑ Improve mood
- ❑ Increase Energy
- ❑ Prevent Bone loss
- ❑ Weight reduction
- ❑ Reduce blood pressure
- ❑ Improve sleep

Are there any BARRIERS or PROBLEMS that limit exercise? *Check all that apply*

- ❑ No barriers
- ❑ Life Transition Period
- ❑ Family Responsibility
- ❑ Depression
- ❑ Time
- ❑ Apparel
- ❑ Work Responsibility
- ❑ Fear
- ❑ Energy
- ❑ Cost
- ❑ Other

EXERCISE SAFETY

a. Do you have any injuries that would make it difficult to exercise? No Yes
If yes, please explain: _____

b. Do you have any joint, muscle, or bone problems that might get worse with exercise? No Yes
If yes, please explain: _____

c. Do you have any breathing problems while exercising? No Yes
If yes, please explain: _____

d. Do you have any balance problems or have had a fall in the last 6 months? No Yes
If yes, please explain: _____

e. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)? No Yes
If yes, please explain: _____

Do you have any of the following health problems? ***Check all that apply***

- ❑ Arrhythmia or irregular heartbeat
- ❑ Arthritis or significant joint pain
- ❑ Chest pain/angina
- ❑ Uncontrolled diabetes
- ❑ Severe or uncontrolled heart failure
- ❑ Uncontrolled asthma
- ❑ Recent heart attack
- ❑ Chronic or unusual fatigue/tiredness
- ❑ Difficulty breathing with activity
- ❑ Other