Pulmonary Rehabilitation Self-Assessment Form

Date: __________

Intake
Name______________________________________________ Date:______________
Address_________________________________________ Phone_____________________
Emergency Contact________________________________ Phone_____________________ 
Age_______________ Sex_______________ Occupation____________________________
Height______________ Weight_________________ Marital Status______________________
Diagnosis________________________________ Referring Physician ________________
Primary Care Physician______________________ Referral Source_____________________ 
Referral Source______________________________________________________________
Have you ever attended a Pulmonary Rehab before?________________________________

Shortness of Breath (MRC Dyspnea Scale):
Please check the statement that best fits your daily level of shortness of breath.
_____ [0] No trouble with shortness of breath except with strenuous exercise such as running or carrying 25 lbs. while walking up hill.

_____ [1] You feel short of breath while walking on a flat level of ground in a hurry or walking up a slight hill.

_____ [2] You walk slower than others of the same age or have to stop to catch your breath while walking on level ground because of shortness of breath.

_____ [3] You have to stop to catch your breath after walking a short distance (less than 100 yards, less than the length of a football field) or after walking for just a few minutes on level ground.

_____ [4] You are too breathless to leave the house or are too breathless to dress and fix meals.

Hospitalizations:
How many times have you been hospitalized in the last year as a result of your pulmonary diagnosis?______________________________
How many ER visits have you had in the last year due to difficulty breathing?___________

Last Hospital Admission_________ Release_______________________

Past Medical History
Do you have a chronic cough? Yes   No    When?______________________________________
Do you cough up sputum? Yes   No  Describe sputum_____________________________________
Do you have any physical limitations that limits your ability to exercise? Explain.______________________________________________________________________________________

Do you have any other medical problems such as:
Cardiovascular disease________ Hypertension________ Diabetes______ G-I problems______ Reflux/ hiatal hernias______ Osteoporosis________ Sinusitis________ Vision or hearing deficit______ Other______

Have you ever or do you have:
Emphysema________ Valley Fever____________________________
Asthma________________ Tuberculosis_________________________
Bronchitis_________________ Pleurisy__________________________
Pneumonia________________ Lung Cancer_______________________
Bronchiectasis____________ Sinus troubles____________________
Blood Clot in lungs__________ Other__________________________
High pressure in lungs________
### Medications

<table>
<thead>
<tr>
<th>Medication name/ strength</th>
<th>Amount and frequency on a daily basis</th>
<th>Time(S) of the day medication is taken</th>
<th>Purpose of medication</th>
<th>Comments you have</th>
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### Sleeping Pattern:

How many total hours of sleep do you get on average? ____________________________

Do you have to as a result of shortness of breath, sleep with your head elevated on more than 1 pillow? Yes No

Do you awaken during the night?_____________ How often?______________________

Why?___________________________________________________________________

### Nutrition Information:

How would you rate your appetite?  ____ Good  ____ Fair____ Poor

Do you get short of breath when you eat?   Yes   No   Sometimes

How many meals do you eat daily?__________________________ Snacks: __________

How many 8 oz. glasses of water do you drink per day? _____________

Do you follow a special diet? Yes No If yes, what type?______________________

Do you consume alcohol? Yes No If yes, what type?______________________

Do you use tobacco products? Yes No If yes, what type?______________________

How much? ___________ How long? __________________________

### Family Support:

Are there any issues/aspects with your family or home situation that would interfere with your rehab sessions or treatment?  No__   Yes___    If yes, explain: __________________________

Do you have family members living in your house that actively participate in your daily living?   Yes   No

Are your family members mentally and emotionally supportive regarding your lung disease and planned/ongoing rehabilitation?  Yes   No    If no, explain: __________________________

### Check any of the following activities that you have difficulty doing without assistance.

(Include activities that you always have someone else do because of your inability to do them).

**Eating:**

- Cutting up your food ___
- Sitting for a whole meal____
- Drinking from a cup_____  

**Meal Preparation:**

- Peeling/cutting up food____
- Stir or steam foods___
- Bending to obtain items____
- Reaching to obtain items____
- Hand washing dishes____
- Loading/unloading dishwasher____
- Setting the table____
- Clearing the table____
- Taking out the garbage____

**Hygiene:**

- Taking a shower or bath____
- Washing your back____
- Washing your legs and feet____
- Drying yourself with a towel____
- Shaving____
- Putting on make up____
Household:

Cleaning: Making the bed______
Running the vacuum or mopping_____
Dusting high and low places_____
Moving chairs or tables to vacuum or dust_____

Laundry:

Sorting clothes____
Getting clothes up or down stairs_____
Using washing machine or dryer____
Folding laundry____
Ironing clothes____

Functional Mobility:

Getting in or out of the tub ______
Getting up or down stairs_______
Opening or closing car doors_____
Walking in a store____
Walking about the house____
Taking out the trash________
Carrying groceries in or out of car____

Miscellaneous:

Difficulty relaxing____
Panic when short of breath____
Fatigue at end of day_______
Holding objects_________
Reaching or lifting things overhead___
Bending to pick things up or tying shoes____

Check the usual household activities that you do:

___Cooking ____Cleaning ___Finances
___Laundry ___Driving ___Yard work ___Grocery shopping

Transportation:

_____ Currently drive ______ Rely on family ______ Rely on Friends
_____ Use public transportation ______ Is a real problem for me

Occupation History:

Current or former occupation: _______________________________________________
Retirement/Disability Date: ________________________________________________
Were you ever exposed to the following:

___ Welding ______ Pottery ______ Asbestos ______ Mines/foundry
___ Gas/fumes ______ Quarry ______ Sandblasting ______ Chemicals
___ Dust

Allergy History:

Do you see an allergist? Yes    No
I am allergic to the following:

Foods: __________________________________________________________
Medications: ___________ Dust _______ Mold_______ Pollens _______ Grass
_________________________ Other

Do you have difficulty breathing when exposed to any of the following:

___ Dust _______ Smog ______ Solvents _______ Humidity
___ Wind ______ Perfumes or cologne ______ Tobacco smoke
____ Changes in temperature or weather

Vaccine History:

Do you receive the flu vaccine annually? _____Yes _____No
Have you ever received the pneumonia vaccine? _____Yes _____No
Exercise Activity:
Do you do exercise on a regular basis? ____ Yes   ____ No
If yes, what do you do? ____________________________________________
What type of exercise equipment do you have at home or have access to?
_______________________________________________________________________

Assistive Devices:
Do you use any of the following on occasion or on a regular basis?
____ Walker   ____ Cane   ____ Wheelchair
____ Electric cart   ____ 4 leg cane   ____ Eye glasses
____ Hearing aids

Respiratory Care Equipment:
Do you have or use any of the following at home?
____ Peak flowmeter   ____ Flutter Valve   ____Pep therapy (aerobika)
____ Mechanical chest percussor   ____ Nebulizer machine   ____ Suction machine
____ BiPAP or ventilator machine   ____ CPAP machine   ____ Oxygen: What liter flow?______
What type of Oxygen:
Concentrator   ____ Tanks   ____ Liquid   ____pHulse   ____Portable
When do you use it? __________________________________________________________

Anticipated Outcomes/ Goals:
What were your symptoms 5 years Ago? _______________________________________
What were your symptoms last year? __________________________________________
What are your symptoms today? _____________________________________________
Please state your goals or what you expect to achieve from this program.
____________________________________________________________________________

Estimate Learning Ability:
______Slow Learner   ____ Needs Review and Reinforcement
______Good Learner   ____ Needs Adaptive Learning Support

Advanced Directive:
Do you have an advanced directive? _____ Yes _____ No
Do you have a power of attorney to make medical decisions? _____ Yes _____ No
Emergency Contact: __________________________________________________________
Emergency Contact Phone Number: ____________________________________________________________________________________

Patient Signature: __________________________________________________________ Date:

For Clinician Only
Data from patient record:
Physician Diagnosis______________________________________GOLD COPD level___________________________
FEV1_________ FEV1/FVC_________ Hb/Hct_________ ABGs_________
Borg ScoreBECK’s______ Score______ MRC Scale___________

Observations
Mental Status________________________________________ Nutritional Status_________
Blood Pressure__________________ Pulse__________________ Edema_________ Skin Color_________
Respirations (rate, rhythm, depth)____________________________________ Sp02_________ Energy_________
Accessory breather YES NO Pursed Lips YES NO Abdominal breathing YES NO
Auscultation________________________________ Other_________

Candidacy
Accept _____ Reject _____ Reason for rejection____________________________________

Medical Director Signature: __________________________________________________ Date:

Clinician Signature: __________________________________________________ Date: