TOWER HEALTH
Advancing Health. Transforming Lives.

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

Medication name/ strength	Amount and frequency on a daily basis	Time(S) of the day medication is taken	Purpose of medication	Comments you have

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 How Much?_____
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 you 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: _____
Environmental: _____ 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 ___pulse ___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:_____