OMB # 0925-0414 Exp: 4/06

- Affix label here-

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name _____M.I._____

Last Name _____

1. Date of exam: ___-___-___ (M/D/Y)

2. Performed by: ___

3. Contact type:

- ☐ 3 Visit
- ☐ 8 Other

4. Visit type:

- ☐ 1 Screening #___
- ☐ 2 Semi-Annual #___
- ☐ 3 Annual #___
- ☐ 4 Non-Routine

Performance Measures

5. Grip strength:

5.1. Side tested:

- ☐ 1 Right
- ☐ 2 Left
- ☐ 3 Attempted, unable to complete on either side
- ☐ 8 Refused
- ☐ 9 Not attempted for safety or health reasons

5.2. Dominance of hand used:

- ☐ 1 Dominant
- ☐ 2 Non-dominant

5.3. Measurement #1: ___ kg

5.4. Measurement #2: ___ kg

6. Single chair stand:

- ☐ 1 Test completed, arises without using her arms
- ☐ 2 Test completed, arises using her arms
- ☐ 3 Attempted, unable to rise from chair
- ☐ 8 Refused
- ☐ 9 Not attempted for safety or health reasons

Repeated chair stands in 15 seconds:

6.1. ___ stands

6.2. ___ stands

7. Timed walk:

- ☐ 1 Test completed or partially completed
- ☐ 2 Attempted, unable to complete one trial
- ☐ 8 Refused
- ☐ 9 Not attempted for safety or health reasons

7.1. Time: ___.___ seconds

7.2. Time: ___.___ seconds

7.3. Assistive device used?

- ☐ 0 No
- ☐ 1 Yes

K _____ V _____