

**Physical activity assessment**

Fort Thompson Service Unit

SDPI Healthy Heart Project

**Diabetes**

**Education**

**Event**

**Physical Activity Assessment: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Stand Down Event: 08/19/11**

1. **What physical activity are you currently doing? Circle activities you currently do daily:**
	1. **Walking e. Bicycling i. Mopping/vacuuming**
	2. **Shopping f. Low impact aerobics j. Running**
	3. **Child care g. Yard work k. Playing basketball**
	4. **Playing catch h. Softball l. Pushing lawn mower**
2. **How many days of the week are you physically active?**

**0 1 2 3 4 5 6 7**

1. **How long are you active? 1-5 min 6-10 min 16-20 min 21-30 min +30**
2. **How intense is your activity?**
	1. **Very easy**
	2. **Breathing a bit hard but can still talk**
	3. **Out of breath**
3. **How many times per week do you do stretching exercises to improve flexibility of your back, neck, shoulders and legs?**
	1. **None**
	2. **Once a week**
	3. **Twice a week**
	4. **Three times a week**
4. **How many times per week do you do strength building exercises such as sit-ups,push-ups, or use weight training equipment?**
	1. **None**
	2. **Once a week**
	3. **Twice a week**
	4. **Three times a week**
5. **Indicate how ready you are to make changes in your current level of physical activity?**
	1. **Haven’t thought about changing**
	2. **Plan to change this month**
	3. **Would like to change but needs assistance in doing so**
	4. **Already quite active/doing enough**
6. **How could you incorporate more activity into your day?(Look at your daily routine and identify areas where slight modifications would lead to an increase in physical activity.)**
	1. **Transportation to work**
	2. **At work**
	3. **In spare/leisure time**
	4. **Organized recreational activities**
	5. **With children(your children, grandchildren, neighbor)**
7. **What limits you from doing more physical activity?**
	1. **Heart disease**
	2. **Diabetes**
	3. **High blood pressure**
	4. **Overweight**
	5. **Osteoporosis**
	6. **Pain with walking-arthritis**
	7. **Breathing problems-asthma-copd**
	8. **Balance problems**
	9. **Knee problems**
	10. **Time**

**NUTRITION ASSESSMENT:**

1. **Do you eat at least 2 pieces of fruit daily? YES NO**
2. **Do you eat at least 5 servings of vegetables daily? YES NO**
3. **Do you usually remove the skin from fried chicken and trim all visible fat from meats? YES NO**
4. **Do you eat high fat foods such as chips, fast food, sausage, bacon?**

 **YES NO**

1. **Do you usually cook with and/or season foods with margarine,butter,oil or lard?**

 **YES NO**

1. **Do you usually choose low-fat dairy products, such as skim or 1% milk, or low-fat yogurt? YES NO**
2. **Do you usually choose high fiber foods, such as whole wheat bread, oatmeal, and bran cereal? YES NO**