PARTICIPANT'S NAME:

Pre-Exercise Assessment

Participant ID:

Venue:_____ Cohort number:_____

DAPA Trial Team
Warwick Clinical Trials Unit
University of Warwick
Gibbet Hill Road
Coventry
CV4 7AL
Tel: 024 7615 0955

Warwick Medical School
CLINICAL TRIALS UNIT

Physiotherapist's initials | Participant ID | Date

Note for Office Use: Enter only data for questions shaded in grey

Signature Log

Name of Physiotherapists (in capitals)	Physiotherapists' signatures	Physiotherapists' initials

Section 1 - Participant details

1.1 Participant's Date of Birth: d d m m m Y Y Y Y

1.2 Participant's age* ☐☐

*bring this value forward to 3.2

Section 2 - Medical information

	Yes	No
2.1 Do you have any heart or circulatory problems, such as angina, high blood pressure, or heart failure ?	☐	☐
2.2 Do you use Glyceryl trinitrate (GTN) spray?	☐*	☐
2.3* Find out when the participant has been advised to use it and record the details below. Ask the participant/carer to bring this along to every exercise class.		
2.4 Do you have any lung disease, such as asthma or bronchitis?	☐	☐

Physiotherapist's initials ☐ Participant ID ☐ Date ☐☐☐☐☐☐

2.5 Do you use an inhaler?	☐ **	☐

**2.6 Find out when the participant has been advised to use it and record the details below. Ask the participant/carer to bring this along to every exercise class.

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2.7 Do you have diabetes?	☐ ***	☐

*** 2.8 Find out the method the participant uses to stabilise low glucose levels and record the details below. Ask the participant/carer to bring along anything they might need to every class.

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	Yes	No
2.9 Do you have any neurological conditions – e.g. Parkinson's disease, previous CVA, MS	☐	☐
2.10 Do you have any joint or muscle pains? Brought on by walking or other physical activity?	☐	☐
2.11 Have you had any operations or broken bones in the past 6 months?	☐	☐
2.12 Have you ever had depression, anxiety or any other psychiatric illness?	☐	☐
2.13 Do you have any other illnesses we need to know about – e.g. cancer, epilepsy, or an acute illness such as the flu?	☐	☐

2.14 General notes/comments RE: medical information-

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2.15 Do you ever get anxious or upset? If you do, what tends to trigger these feelings? And what tend to help you feel better?

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Physiotherapist's initials ☐ Participant ID ☐ Date ☐☐☐☐☐☐

Section 3 - Six minute walk test

3.1 Gender: Male ☐ Female ☐

3.2 Age: _____ *See section 1.2

3.3 Weight (in kg): _____

3.4 Resting heart rate: _____

Six Minute Walk Test

3.5 Distance of 1 lap (in meters): _____

3.6 Number of laps completed in six minutes: _____

3.7 Distance of partial lap completed (in meters): _____

3.8 Average heart rate achieved during the six minute walk test: _____

3.9 Was a walking aid used during the six minute walk test? Yes ☐ No ☐

3.10 If a walking aid was used, please specify by selecting an option below:

Stick	Sticks	Crutches	Three wheeled walker	Wheeled frame	Non-wheeled frame
☐	☐	☐	☐	☐	☐

Other:.....

3.11 Was the test completed?: Yes ☐** No ☐*

*3.12 **If No**, record reason/s why the test was stopped below (Tick all that apply):

	Yes	No		Yes	No
Became anxious	☐	☐	Declined to continue	☐	☐
Signs of overexertion	☐	☐	Pain	☐	☐
Became unsteady	☐	☐	Test Disrupted	☐	☐

Other:.....
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** 3.13 **If Yes**, was the test completed in the standardised manner? Yes ☐ No ☐

If No, please describe the manner in which it was completed:

3.14 General comments (e.g. on any subjective and objective signs of exertion observed during test)

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3.15 Six minute walk test values:

Distance (m).....

METs.....

%HRR.....

Heart rate walking speed index.....

3.16 Calculated intensity values:

Watts-	Low	Moderate	Hard .....
Heart rate (bpm)-	Low (40% HRR).....	Moderate (60% HRR).....	Hard (80% HRR) .....
METs-	Low	Moderate	Hard .....

Section 4 –Previous and current activity levels

4.1 What sports or physical activities have you taken part in previously?

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4.2 What sports or physical activities have you enjoyed in more recent years?

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Physiotherapist's initials | Participant ID | Date

Section 5 – Prescribing exercises

5.1 Does the participant have difficulties doing a sit to stand from the venue's standard height chair? **Yes** ☐* **No** ☐

*If Yes, tick to identify adaptations which may be required for sit-stand exercise :

	Yes	No
Increase seat height with riser cushion	☐	☐
Balance poor, provide close supervision during exercise	☐	☐

Further details of physical assistance required or other adaptations needed:

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5.2 Does the participant have restricted flexion in their shoulder(s)? **Yes** ☐* **No** ☐

*If Yes, tick to identify the shoulder(s) that is/are affected (Tick one box only):

Left only ☐ Right only ☐ Both ☐

5.3 Does the participant have restricted abduction in their shoulder(s)? **Yes** ☐* **No** ☐

*If Yes, tick to identify the shoulder(s) that is/are affected (Tick one box only):

Left only ☐ Right only ☐ Both ☐

Details of physical assistance required or adaptations needed for the; forward raise, lateral raise or shoulder press exercises:

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5.4 Asses the participants' ability to; get on and off of the bike, and pedal.

Seat height on bike:.....

Details of assistance required (physical or verbal) or adaptations needed:

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Physiotherapist's initials | Participant ID | Date

Section 6 – Concluding activities checklist

	Yes	No
6.1 Appointment postcard given?	☐	☐*
6.2 Discussed attendance and given reassurance RE. gradual build-up of exercises?	☐	☐*
6.3 Given exercise information leaflet with brief explanation and request to read?	☐	☐*
6.4 Introduced sign in sheet?	☐	☐*
6.5 Informed the carer that they are welcome to; watch the exercise classes, meet with the other carers during the class (at suggested location), take part in action planning meetings?	☐	☐*
6.6 Provided with travel claim form and instructions for completion?	☐	☐*
6.7 Explained how useful if they call/text to say if cannot attend (as for trial purposes we have to call to check them whenever they do not attend)?	☐	☐*

*If No ticked for any of items 6.1-6.7, ensure the; information is covered, or action is completed at the nearest opportunity.

Thank participant (and carer) for their time.

Physiotherapist's initials ☐ Participant ID ☐ Date ☐☐☐☐☐☐

Section 7- Other considerations

	Yes	No
7.1 Difficulties with communication/ comprehension observed?	☐	☐

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7.2 Significant motor impairment observed?	☐	☐

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7.3 When following verbal instructions, did the participant require additional physical facilitation or simplified verbal prompting?	☐	☐

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Section 8 – Additional information / Changes in participant's status