

Date: \_\_\_\_\_

**Over the last 7 days**

- Are you having any symptoms related to your heart?       Yes       No
  - Leg cramping with activity       Short of breath while lying down
  - Shortness of breath       Irregular heartbeats
  - Swollen ankles       Fainting spells
  - Fatigue      Other \_\_\_\_\_
  - Lightheadedness      \_\_\_\_\_
- How many days did you exercise both at home and in rehab? \_\_\_\_\_ (0-7)
- How many exercise minutes did you average per day? (circle the best answer)  
10 mins      20 mins      30 mins      45 mins      60 mins      \_\_\_\_\_ mins.
- How many days did you forget or did not take your medications as prescribed? \_\_\_\_\_ (0-7)  
Medications changes during program: \_\_\_\_\_

**Current Diet:**  Regular     Low Sodium     Low Fat     Diabetes     Fluid Restriction

**During Program:** # of Emergency visits \_\_\_\_\_ # of hospitalizations \_\_\_\_\_

Due to \_\_\_\_\_

**Work Status:**     Full/Part Time     Unemployed     Disabled     Retired

**Tobacco Use:**     No     Yes     Cigarettes     Vape     Cigar     Pipe     Smokeless  
How often \_\_\_\_\_ # per day \_\_\_\_\_ Packs per week \_\_\_\_\_

**Alcohol Use:**     No     Yes    # drinks/day \_\_\_\_\_, # days/week \_\_\_\_\_ Type: \_\_\_\_\_

**Did you reach your personal goals during your initial evaluation for rehab?**     Yes     No



## Cardiac Rehabilitation Readiness for Change

Name: \_\_\_\_\_

pre     post

Date: \_\_\_\_\_

Please circle the statement that best describes your current outlook regarding the modifiable risk factors for heart disease:

<b>1. Controlling blood pressure</b>	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I've never had high blood pressure
<b>2. Controlling blood sugars</b>	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I'm not a diabetic or had elevated fasting blood sugars.
<b>3. Controlling Cholesterol levels</b>	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I've never had high cholesterol.
<b>4. Stop Smoking</b>	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I've never smoked or quit more than 6 months ago.
<b>5. Stress Management</b>	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	
<b>6. Weight Loss</b>	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	I'm at goal weight.
<b>7. Exercising</b>	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	
<b>8. Healthier Diet</b>	I'm not ready to change right now.	I'm thinking about doing it sometime.	I might do it in the next month.	I'm doing it right now.	I've been doing it for more than 6 months.	

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Instructions: "I have some questions to ask you regarding your current level of physical activity. Your answers to these questions will help us determine your initial exercise levels. Please answer 'yes' or 'no' to each question."

Can you:	Circle	Weight
1. Take care of yourself, that is, eat, dress, bathe, or use the toilet?	Yes No	2.75
2. Walk indoors, such as around your house?	Yes No	1.75
3. Walk a block or two on level ground?	Yes No	2.75
4. Climb a flight of stairs or walk up a hill?	Yes No	5.50
5. Run a short distance?	Yes No	8.00
6. Do light work around the house like dusting or washing dishes?	Yes No	2.70
7. Do moderate work around the house like vacuuming, sweeping floors, or carrying groceries?	Yes No	3.50
8. Do heavy work around the house like scrubbing floors or lifting or moving heavy furniture?	Yes No	8.00
9. Do yardwork like raking leaves, weeding, or pushing a power mower?	Yes No	4.50
10. Have sexual relations?	Yes No	5.25
11. Participate in moderate recreational activities, like golf, bowling, dancing, doubles tennis, or football?	Yes No	6.00
12. Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?	Yes No	7.50

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Duke Activity Status Index (DASI)= \_\_\_\_\_ (Sum of weights of "yes" replies)

VO<sub>2</sub>= \_\_\_\_\_ ml/kg/min      MET Level= \_\_\_\_\_

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## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING   0   +      +      +       
=Total Score:     

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult





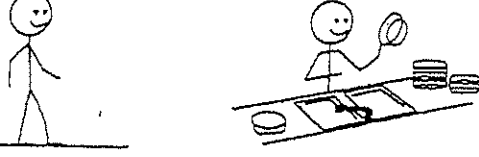
Very difficult

Extremely difficult

Dartmouth COOP Functional Assessment Charts

# Physical Fitness






During the past 2 weeks,  
What was the hardest physical activity  
you could do for at least 2 minutes?

<p><b>Very heavy</b> – for example:</p> <ul style="list-style-type: none"> <li>• Run, fast pace</li> <li>• Carry a heavy load upstairs or uphill (25 pounds or 10 kilograms)</li> </ul>		1
<p><b>Heavy</b> – for example:</p> <ul style="list-style-type: none"> <li>• Jog, slow pace</li> <li>• Climb stairs or a hill at moderate pace</li> </ul>		2
<p><b>Moderate</b> – for example:</p> <ul style="list-style-type: none"> <li>• Walk, medium pace</li> <li>• Carry a heavy load on level ground (25 pounds or 10 kilograms)</li> </ul>		3
<p><b>Light</b> – for example:</p> <ul style="list-style-type: none"> <li>• Walk, medium pace</li> <li>• Carry light load on level ground</li> </ul>		4
<p><b>Very light</b> – for example:</p> <ul style="list-style-type: none"> <li>• Walk, slow pace</li> <li>• Wash dishes</li> </ul>		5

# Feelings

During the past 2 weeks,






How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable or downhearted and blue?

Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

Dartmouth COOP Functional Assessment Charts

# Daily Activities



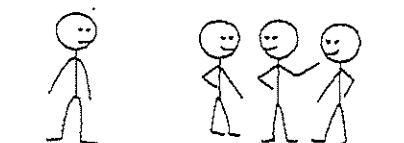


During the past 2 weeks,  
How much difficulty have you had doing your usual activities or tasks,  
both inside and outside the house because of your physical and emotional health?

No difficulty at all		1
A little bit of difficulty		2
Some difficulty		3
Much difficulty		4
Could not do		5

Dartmouth COOP Functional Assessment Charts

# Social Activities

During the past 2 weeks,  
 Has your physical and emotional health limited  
 your social activities with family, friends, neighbors or groups?






Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5



Dartmouth COOP Functional Assessment Charts



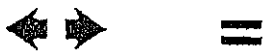


# Pain

During the past 2 weeks,  
How much bodily pain have you generally had?

No pain		1
Very mild pain		2
Mild pain		3
Moderate pain		4
Severe pain		5

# Change In Health






How would you rate your overall health now compared to 2 weeks ago?

Much better		1
A little better		2
About the same		3
A little worse		4
Much worse		5

Dartmouth COOP Functional Assessment Charts

# Overall Health

During the past 2 weeks,  
how would you rate your health in general?

Excellent		1
Very good		2
Good		3
Fair		4
Poor		5

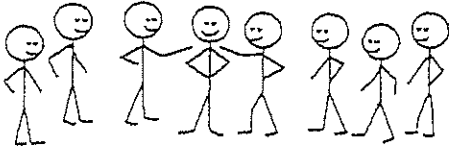
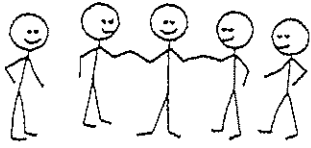
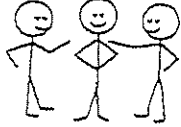


Dartmouth COOP Functional Assessment Charts

# Social Support

During the past 2 weeks,

was someone available to help you if you needed and wanted help? For example, if you:

- felt nervous, lonely, or blue
- needed someone to talk to
- needed help just taking care of yourself
- got sick and had to stay in bed
- needed help with daily chores

Yes, as much as I wanted		1
Yes, quite a bit		2
Yes, some		3
Yes, a little		4
No, not at all		5

# Quality of Life

How have things been going for you during the past 2 weeks?

	Very well: could hardly be better	1
	Pretty good	2
	Good and bad parts about equal	3
	Pretty bad	4
	Very bad: could hardly be worse	5

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Score: \_\_\_\_\_

1. What should a normal total cholesterol level be? < \_\_\_\_\_ mg/dl.
2. What is a normal blood pressure reading? \_\_\_\_/\_\_\_\_ mm/Hg
3. List 2 risk factors for heart disease:
  1. \_\_\_\_\_
  2. \_\_\_\_\_
4. List 2 ways to manage stress:
  1. \_\_\_\_\_
  2. \_\_\_\_\_
5. List 2 things you can do to prevent further progression of your heart disease:
  1. \_\_\_\_\_
  2. \_\_\_\_\_
6. Nitroglycerin for chest pain should be taken \_\_\_\_\_ minutes apart, up to \_\_\_\_\_ tablets.
7. How many times per week should you exercise? \_\_\_\_\_



# RATE YOUR PLATE

Think about the way you usually eat. For each food choice, put a check mark in column A, B or C. Bring the completed form to your next clinic visit.

\*If you are a vegetarian, check column A for these(\*) topics.

	A	B	C
1. MEAT CUTS* fresh beef pork, lamb, veal	<input type="checkbox"/> Usually eat: lean cuts from the round, loin or leg; ham Or, seldom eat meat.	<input type="checkbox"/> Sometimes eat: higher-fat cuts, such as chuck, ribs, brisket, T- bone steak, prime rib	<input type="checkbox"/> Usually/often eat: higher-fat cuts
2. CHICKEN, TURKEY*	<input type="checkbox"/> Usually eat: without skin	<input type="checkbox"/> Sometimes eat: with skin	<input type="checkbox"/> Usually eat: with skin
3. GROUND MEAT & POULTRY*	<input type="checkbox"/> Usually eat: 5-7% fat (93-95% lean); ground turkey breast Or, seldom eat.	<input type="checkbox"/> Usually eat: turkey (dark & white 10-15% fat; ground meat)	<input type="checkbox"/> Usually/often eat: regular ground meat, with 20% fat or more
4. PROCESSED MEAT & POULTRY* cold cuts, hot dogs, sausage, breakfast meats	<input type="checkbox"/> Usually eat: lower-fat choices from lean meat or poultry; veggie breakfast links Or, seldom eat.	<input type="checkbox"/> Sometimes eat: higher-fat choices, such as salami, bologna, hot dogs, bacon, sausage	<input type="checkbox"/> Usually/often eat: higher-fat choices
5. PORTION SIZE OF MEAT & POULTRY* cooked, unprocessed	<input type="checkbox"/> Usually eat: small portions (3 oz.) deck of cards size	<input type="checkbox"/> Usually eat: medium portions (4-6 oz.)	<input type="checkbox"/> Usually/often eat: large portions (7 oz. or more)
6. FISH, SHELLFISH*	<input type="checkbox"/> Usually eat: twice a week or more, especially oily fish like salmon, herring or sardines	<input type="checkbox"/> Usually eat: any type once a week	<input type="checkbox"/> Usually eat: any type less than once a week
7. COOKING METHOD* for poultry, fish, meat	<input type="checkbox"/> Usually: cook without added fat or use vegetable oil spray	<input type="checkbox"/> Sometimes: cook with added fat or deep fry	<input type="checkbox"/> Usually/often: cook with added fat or deep fry
8. MEATLESS MEALS veggie burgers, vegetable or bean soups, meatless spaghetti sauce, tofu, rice & beans	<input type="checkbox"/> Usually eat: twice a week or more	<input type="checkbox"/> Usually eat: less than twice a week	<input type="checkbox"/> Rarely eat: meatless meals
9. WHOLE EGGS*	<input type="checkbox"/> Usually eat: 3 or less a week OR egg substitutes OR egg whites only	<input type="checkbox"/> Sometimes eat: 4 or more a week	<input type="checkbox"/> Usually eat: 4 or more a week
10. MILK includes yogurt, cream	<input type="checkbox"/> Usually use: 1% or skim milk, fat-free or low-fat yogurt, fat-free ½ & ½	<input type="checkbox"/> Sometimes use: 2% or whole milk, full- fat yogurt, regular ½ & ½	<input type="checkbox"/> Usually use: 2% or whole milk, full- fat yogurt, light cream



PLATE

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Rate Your Plate Survey

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<b>11. CHEESE*</b> includes cheese for pizza, sandwiches, snacks, mixed dishes, etc.	<input type="checkbox"/> <b>Usually eat:</b> reduced-fat or part-skim Or, <b>seldom eat.</b>	<input type="checkbox"/> <b>Sometimes eat:</b> regular cheese, such as cheddar, Swiss, and American	<input type="checkbox"/> <b>Usually eat:</b> regular cheese
<b>12. DAIRY FOODS</b> 1 serving: 1 c. milk or yogurt, 1 ½ oz. cheese	<input type="checkbox"/> <b>Usually eat or drink</b> 2 or more servings a day	<input type="checkbox"/> <b>Usually eat or drink:</b> 1 serving a day	<input type="checkbox"/> <b>Rarely eat or drink</b>
<b>13. WHOLE GRAINS</b> 1 serving= 1 oz slice bread; ½ English muffin; 1 c. cereal; ½ c. rice, pasta; 5 crackers; tortilla; mini bagel, 3 c. light popcorn	<input type="checkbox"/> <b>Usually eat:</b> <b>3 or more servings a day</b> , 100% whole wheat bread & pasta, brown rice, whole grain cereals, i.e., oatmeal, raisin bran, Wheaties®	<input type="checkbox"/> <b>Sometimes eat:</b> 1 or 2 servings a day	<input type="checkbox"/> <b>Usually eat:</b> mostly refined grains, i.e., white bread, white rice, saltine crackers, corn flakes, Rice Krispies®, Special K®
<b>14. FRUITS &amp; VEGETABLES</b> includes legumes 1 c. = medium whole fruit or potato, large tomato or ear corn, 2 c. raw leafy greens	<input type="checkbox"/> <b>Usually eat:</b> 4-5 cups a day	<input type="checkbox"/> <b>Usually eat:</b> 2-3 cups a day	<input type="checkbox"/> <b>Usually eat:</b> 0-1 cup a day
<b>15. COOKING METHOD</b> for vegetables, pasta, rice	<input type="checkbox"/> <b>Usually prepare:</b> without fat & sauces OR use vegetable oil spray	<input type="checkbox"/> <b>Sometimes prepare:</b> with sauce, butter, margarine, oil	<input type="checkbox"/> <b>Usually prepare:</b> with sauce, butter, margarine, oil
<b>16. FAT TYPE IN COOKING</b> includes baking	<input type="checkbox"/> <b>Usually use:</b> olive or Canola oil Or, usually cook <b>without</b> added fat.	<input type="checkbox"/> <b>Usually use:</b> other oils, tub margarine	<input type="checkbox"/> <b>Usually use:</b> butter, bacon drippings, stick margarine, lard, shortening
<b>17. SALT FROM PROCESSED FOODS</b>	<input type="checkbox"/> <b>Always/usually:</b> compare and choose lower-sodium options	<input type="checkbox"/> <b>Sometimes:</b> consider sodium content	<input type="checkbox"/> <b>Rarely/never:</b> consider sodium content
<b>18. SPREADS</b> added at the table on bread, potatoes, vegetables, pancakes, sandwiches, etc.	<input type="checkbox"/> <b>Usually use:</b> spray or light tub margarine Or, <b>seldom</b> <b>use.</b>	<input type="checkbox"/> <b>Usually use:</b> regular tub margarine	<input type="checkbox"/> <b>Usually use:</b> butter or stick margarine
<b>19. SALAD DRESSINGS, MAYONNAISE</b>	<input type="checkbox"/> <b>Usually use:</b> fat-free or low-fat salad dressings & mayonnaise Or, <b>seldom use.</b>	<input type="checkbox"/> <b>Usually use:</b> light salad dressings & mayonnaise	<input type="checkbox"/> <b>Usually use:</b> regular salad dressings & mayonnaise
<b>20. SNACK FOODS</b>	<input type="checkbox"/> <b>Usually eat:</b> plain pretzels, light popcorn, baked chips Or, <b>seldom eat.</b>	<input type="checkbox"/> <b>Sometimes eat:</b> regular chips & popcorn, flavored pretzels	<input type="checkbox"/> <b>Usually/often eat:</b> regular chips & popcorn



PLATE

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<b>21. NUTS, SEEDS</b> includes nut butters serving size =1/4 c. nuts, 2 T. peanut butter	<input type="checkbox"/> <b>Usually eat:</b> 3 servings or more a week	<input type="checkbox"/> <b>Usually eat:</b> 1-2 servings a week	<input type="checkbox"/> <b>Usually eat:</b> 1 or less serving a week  Or, <b>seldom eat.</b>
<b>22. FROZEN DESSERTS</b>	<input type="checkbox"/> <b>Usually eat:</b> sherbet, sorbet, fruit juice bars, low-fat ice cream or frozen yogurt Or, <b>seldom eat.</b>	<input type="checkbox"/> <b>Sometimes eat:</b> regular ice cream, ice cream bars/sandwiches	<input type="checkbox"/> <b>Usually eat:</b> regular ice cream, ice cream bars/sandwiches
<b>23. SWEETS, PASTRIES, CANDY</b>	<input type="checkbox"/> <b>Usually eat:</b> angel food cake, low-fat or fat-free products Or, <b>seldom eat.</b>	<input type="checkbox"/> <b>Sometimes eat:</b> donuts, cookies, cake, pie, pastry, or chocolate candy	<input type="checkbox"/> <b>Usually/often eat:</b> donuts, cookies, cake, pie, pastry or chocolate candy
<b>24. EATING OUT</b> eat in or take out, any meal	<input type="checkbox"/> <b>Seldom eat out</b> Or, <b>usually choose</b> <b>lower-fat menu items</b>	<input type="checkbox"/> <b>Usually eat:</b> 1-2 times a week	<input type="checkbox"/> <b>Usually eat:</b> 3 times a week or More
<b>Find Your Score = A+B+C</b>	<b># A: X3=</b>	<b># B: X2=</b>	<b># C: X1=</b>
<b>Score</b>	<b>Score</b>	<b>Score</b>	<b>Score</b>

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**If your score is:**

- 58 - 72: You are making many healthy choices.
- 41 - 57: There are some ways you can make your eating habits healthier.
- 24 - 40: There are many ways you can make your eating habits healthier.

**Look at your Rate Your Plate responses.**

Do you have any responses in Column A? You are already making some heart healthy choices.

Look at your responses in Columns B and C.

Where you checked Column C, can you start eating more like Column B? Over time, move toward Column A.

Think about changes. Write down eating changes you are ready to consider.

Change #1:

Change #2:

Change #3:

Begin today. Make changes a little at a time. Let your new way of eating become a healthy habit.

Set goals. After discussion with your doctor, write down eating changes you are ready to work on.

Goal 1:

Goal 2:

Goal 3:



PLATE

/ /

## Medical West Cardiac Rehabilitation

*Please take a few minutes to complete this satisfaction survey.*

	Excellent	Very Good	Good	Fair	Poor	N/A
1. Scheduled appointment times that were convenient for your schedule.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Information was provided to help you achieve your health goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Explanation of exercise workloads and self-monitoring skills.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Treatment provided by staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Promptness of answering your questions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Overall rating of short education sessions during exercise.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. You were provided with easy to understand information for your condition and/or concerns.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. The staff treated you with respect and Dignity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. The exercise program overall.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Overall rating of program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Would you recommend the Cardiac Rehabilitation Program to other:  Yes  No

12. Would you return to Medical West for medical care:  Yes  No

13. Age:  18-34  35-54  55-64  65+

14.  Female  Male

15. How did you hear about us?

Physician  Hospital stay  Media/Website/Printed material  Family/Friends

Additional comments or suggestions: \_\_\_\_\_

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Please return completed survey to the evaluation box. Thank you

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