



## **PANINI Case Report Form**

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## Patient history form

Ask participant if he/she has or has ever had:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Diabetes type 1                          | <input type="checkbox"/> Atherosclerosis                            | <input type="checkbox"/> Cataracts                |
| <input type="checkbox"/> Diabetes type 2                          | <input type="checkbox"/> Angina pectoris                            | <input type="checkbox"/> Kidney failure           |
| <input type="checkbox"/> High blood pressure                      | <input type="checkbox"/> Cardiovascular disease                     | <input type="checkbox"/> Osteoarthritis           |
| <input type="checkbox"/> High cholesterol                         | <input type="checkbox"/> Myocardial infarction                      | <input type="checkbox"/> Rheumatoid arthritis     |
| <input type="checkbox"/> Cancer (type)<br>_____                   | <input type="checkbox"/> Stroke                                     | <input type="checkbox"/> Hypothyroidism           |
| <input type="checkbox"/> Chronic Obstructive Pulmonary<br>Disease | <input type="checkbox"/> Transient ischemic<br>attack (mini stroke) | <input type="checkbox"/> Hyperthyroidism          |
| <input type="checkbox"/> Pulmonary embolism                       | <input type="checkbox"/> Epilepsy                                   | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Parkinson's disease                        | <input type="checkbox"/> Dementia (type)<br>_____ |

Other medical conditions (please list):

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## Mini Nutritional Assessment (MNA®)

Complete the questionnaire by filling the boxes with the appropriate numbers.

### Screening

**A Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?**

- 0 = severe decrease in food intake  
1 = moderate decrease in food intake  
2 = no decrease in food intake

**B Weight loss during the last 3 months**

- 0 = weight loss greater than 3kg (6.6lbs)  
1 = does not know  
2 = weight loss between 1 and 3kg (2.2 and 6.6 lbs)  
3 = no weight loss

**C Mobility**

- 0 = bed or chair bound  
1 = able to get out of bed / chair but does not go out  
2 = goes out

**D Has suffered psychological stress or acute disease in the past 3 months?**

- 0 = yes      2 = no

**E Neuropsychological problems**

- 0 = severe dementia or depression  
1 = mild dementia  
2 = no psychological problems

**F Body Mass Index (BMI) = weight in kg / (height in m)<sup>2</sup>**

- 0 = BMI less than 19  
1 = BMI 19 to less than 21  
2 = BMI 21 to less than 23  
3 = BMI 23 or greater

**Screening score (subtotal max. 14 points)**

12-14 points:  Normal nutritional status

8-11 points:  At risk of malnutrition

0-7 points:  Malnourished

For a more in-depth assessment, continue with questions G-R

### Assessment

**G Lives independently (not in nursing home or hospital)**

- 1 = yes      0 = no

**H Takes more than 3 prescription drugs per day**

- 0 = yes      1 = no

**I Pressure sores or skin ulcers**

- 0 = yes      1 = no

**J How many full meals does the patient eat daily?**

- 0 = 1 meal  
1 = 2 meals  
2 = 3 meals

**K Selected consumption markers for protein intake**

- At least one serving of dairy products (milk, cheese, yoghurt) per day      yes  no
  - Two or more servings of legumes or eggs per week      yes  no
  - Meat, fish or poultry every day      yes  no
- 0.0 = if 0 or 1 yes  
0.5 = if 2 yes  
1.0 = if 3 yes

**L Consumes two or more servings of fruit or vegetables per day?**

- 0 = no      1 = yes

**M How much fluid (water, juice, coffee, tea, milk...) is consumed per day?**

- 0.0 = less than 3 cups  
0.5 = 3 to 5 cups  
1.0 = more than 5 cups

**N Mode of feeding**

- 0 = unable to eat without assistance  
1 = self-fed with some difficulty  
2 = self-fed without any problem

**O Self view of nutritional status**

- 0 = views self as being malnourished  
1 = is uncertain of nutritional state  
2 = views self as having no nutritional problem

**P In comparison with other people of the same age, how does the patient consider his / her health status?**

- 0.0 = not as good  
0.5 = does not know  
1.0 = as good  
2.0 = better

**Q Mid-arm circumference (MAC) in cm**

- 0.0 = MAC less than 21  
0.5 = MAC 21 to 22  
1.0 = MAC greater than 22

**R Calf circumference (CC) in cm**

- 0 = CC less than 31  
1 = CC 31 or greater

**Assessment (max. 16 points)**

**Screening score**

**Total Assessment (max. 30 points)**

#### References

- Vellas B, Villars H, Abellan G, et al. Overview of the MNA® - Its History and Challenges. *J Nutr Health Aging*. 2006; **10**:456-465.
- Rubenstein LZ, Harker JO, Salva A, Guigoz Y, Vellas B. Screening for Undernutrition in Geriatric Practice: Developing the Short-Form Mini Nutritional Assessment (MNA-SF). *J Geront*. 2001; **56A**: M366-377
- Guigoz Y. The Mini-Nutritional Assessment (MNA®) Review of the Literature - What does it tell us? *J Nutr Health Aging*. 2006; **10**:466-487.

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For more information: [www.mna-elderly.com](http://www.mna-elderly.com)

#### Malnutrition Indicator Score

- 24 to 30 points  Normal nutritional status  
17 to 23.5 points  At risk of malnutrition  
Less than 17 points  Malnourished

Save

Print

Reset

**Nestlé**  
**NutritionInstitute**

### Height and weight

Let the participant take off their shoes and heavy clothes (vest, coat, sweater). Let the participant empty their pockets (wallet, keys, etc.).

**Note:** Do not correct the weight for the clothes

Height (without shoes)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> cm
Pacemaker?	<input type="checkbox"/> Yes → weighing scale <input type="checkbox"/> No → BIA + weighing scale
Weight (without correction for clothes)	Weighing scale: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> kg
Was the measurement possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason _____

### Dual-energy X-ray absorptiometry

Performed Yes <input type="checkbox"/> No <input type="checkbox"/>	Model of DXA _____
Total mass <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> kg Total fat-free soft tissue mass <input type="text"/> <input type="text"/> <input type="text"/> kg Total fat mass <input type="text"/> <input type="text"/> <input type="text"/> kg	Total bone mineral content <input type="text"/> <input type="text"/> <input type="text"/> kg T score <input type="text"/> <input type="text"/>

### Bioelectrical Impedance Analysis (BIA)

Let the participant take off their shoes and heavy clothes (vest, coat, sweater). Let the participant empty their pockets (wallet, keys, etc.). Let the patient also take off socks, panty and compression stockings. The feet must be fully exposed.

**Note:** Check if the patient has a pacemaker. Do not perform the BIA measurement if the patient has a pacemaker

Pacemaker?	<input type="checkbox"/> Yes → <b>NO BIA!!!</b> <input type="checkbox"/> No
Alcohol consumption in last 8 h?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Time BIA measurement	<input type="text"/> : <input type="text"/> hh:mm (write hours in 0-24 format)
Time last meal	<input type="text"/> : <input type="text"/> hh:mm
Time last drink	<input type="text"/> : <input type="text"/> hh:mm
Time last visit toilet	<input type="text"/> : <input type="text"/> hh:mm
Weight	BIA: <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> kg
BMI (calculated by BIA)	<input type="text"/> <input type="text"/> . <input type="text"/> kg/m <sup>2</sup>
Muscle mass	Skeletal muscle mass: <input type="text"/> <input type="text"/> . <input type="text"/> kg SMI: <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> kg/m <sup>2</sup> <small>(skeletal muscle mass (kg)/height (m)<sup>2</sup>)</small>
Fat mass percentage	<input type="text"/> <input type="text"/> . <input type="text"/> %
Was the BIA measurement possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason _____

Circumferences	
<b>Put on anti-slip socks.</b> If not possible (e.g. orthosis, orthopaedic shoes) , give an explanation: _____	
Waist circumference	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> cm
Hip circumference	<input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> cm
Calf circumference	<input type="text"/> <input type="text"/> , <input type="text"/> cm right <input type="text"/> <input type="text"/> , <input type="text"/> cm left
Mid-arm circumference	<input type="text"/> <input type="text"/> , <input type="text"/> cm
Were the measurements possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No: Which one: _____ Reason: _____

Handgrip strength	
Dominant hand	Right <input type="checkbox"/> Left <input type="checkbox"/>
Adjust the dynamometer. Arms straight and parallel to the body. 3x Maximal effort on the right and left alternately. <b>Encourage with “harder, harder, harder”</b>	
<u>Right</u> 1 <sup>st</sup> trial <input type="text"/> <input type="text"/> . <input type="text"/> kg 2 <sup>nd</sup> trial <input type="text"/> <input type="text"/> . <input type="text"/> kg 3 <sup>rd</sup> trial <input type="text"/> <input type="text"/> . <input type="text"/> kg	<u>Left</u> 1 <sup>st</sup> trial <input type="text"/> <input type="text"/> . <input type="text"/> kg 2 <sup>nd</sup> trial <input type="text"/> <input type="text"/> . <input type="text"/> kg 3 <sup>rd</sup> trial <input type="text"/> <input type="text"/> . <input type="text"/> kg
Maximal value right <input type="text"/> <input type="text"/> . <input type="text"/> kg	Maximal value left <input type="text"/> <input type="text"/> . <input type="text"/> kg
Was the measurement possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason _____
Note (e.g. arthrosis which has influenced the measurement)	_____
Accelerometry	
Was accelerometry performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for how many days? <input type="text"/> days Model of accelerometer: _____ Where was the accelerometer positioned? <input type="checkbox"/> Waist <input type="checkbox"/> Back <input type="checkbox"/> Ankle <input type="checkbox"/> Wrist

## Short Physical Performance Battery (SPPB, Guralnik, J. M et al., 1994)

### Balance tests

**Note:** Perform the balance tests at the designated location in the room and standardize in every room. Let the patient choose a preferred foot for the semi-tandem and tandem stand. After this the patient cannot switch so the preferred foot stays the same. **Give the following instruction: “stand as still as possible with the arms along the body”.** Try a maximum of 3 trials if the patient is not able to maintain for 10 seconds.

	Score	Number of trials (max of 3)
<u>Side-by-side stand 10s</u>  Feet together side-by-side	Held for 10s <input type="checkbox"/> 1 point Not held for 10s <input type="checkbox"/> 0 points Not attempted <input type="checkbox"/> 0 points	<input type="checkbox"/>
<u>Semi-tandem stand 10s</u>  Heel of one foot against side of big toe of the other	Held for 10s <input type="checkbox"/> 1 point Not held for 10s <input type="checkbox"/> 0 points Not attempted <input type="checkbox"/> 0 points	<input type="checkbox"/>
<u>Tandem stand 10s</u>  Feet aligned heel to toe	Held for 10s <input type="checkbox"/> 2 points Not held 3 – 9.99s <input type="checkbox"/> 1 point Held for < 3s <input type="checkbox"/> 0 points Not attempted <input type="checkbox"/> 0 points	<input type="checkbox"/>

Was the measurement possible?	<input type="checkbox"/> Yes  <input type="checkbox"/> No, reason _____
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#### 4 meter walk

**Note:** Perform the walk test preferable without the use of walking aid. Give the participant the instruction to walk at their usual pace. Stand over the 4-meter line and start and stop the measurement when the whole foot lands behind the corresponding line on the ground. When the participant is very instable, then walk diagonally behind the participant

	Time (s)	Score
<b>Start:</b> 0 meter (directly after the line) <b>Stop:</b> 4 meter, walk through to approx. 5 meter to prevent slowing down before the end of the course  First measurement:  Second measurement:	<div style="margin-bottom: 20px;"> <input type="text"/>.<input type="text"/><input type="text"/> s         </div> <input type="text"/> . <input type="text"/> <input type="text"/> s	Please report both times, but use the best of the 2 to score.  <div style="margin-bottom: 10px;">Time &gt; 8.70s      <input type="checkbox"/> 1 point</div> <div style="margin-bottom: 10px;">Time 6.21 – 8.70s      <input type="checkbox"/> 2 points</div> <div style="margin-bottom: 10px;">Time 4.82 – 6.20s      <input type="checkbox"/> 3 points</div> <div style="margin-bottom: 10px;">Time &lt; 4.82s      <input type="checkbox"/> 4 points</div> <div style="margin-bottom: 10px;">Not able to walk      <input type="checkbox"/> 0 points</div>

Was the measurement possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason _____
Can the patient walk without a walking aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no: With which hand was the walking aid held?	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both
If no: Which walking aid was used?	<input type="checkbox"/> Rollator <input type="checkbox"/> Walking stick <input type="checkbox"/> Other: _____
Gait speed in meters per second, based on the fastest time (4/time)	<input type="text"/> . <input type="text"/> <input type="text"/> m/s

### Chair stand test

**Pre-test:** Participant fold their arms across their chest and try to stand up once from a chair.

	Time (s)	Score
<p>Measures the time required to perform 5 rises from a chair to an upright position as fast as possible without the use of the arms.</p> <p>5 rises:</p> <ul style="list-style-type: none"> <li>Arms crossed on chest</li> <li>Knees bent 90° by adjusting the piano chair.</li> <li>Straighten the pelvis</li> <li>Start: from sitting, say “start” and start the time</li> <li>Count out loud the number of sits</li> <li>Stop: stand 5<sup>th</sup> time</li> </ul>	<div style="border: 1px solid black; width: 40px; height: 40px; margin: 0 auto; display: flex; align-items: center; justify-content: center;"> <div style="border-right: 1px solid black; width: 20px; height: 20px;"></div> <div style="border-right: 1px solid black; width: 20px; height: 20px;"></div> <span style="margin: 0 5px;">.</span> <div style="border-right: 1px solid black; width: 20px; height: 20px;"></div> <div style="border-right: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="margin-top: 5px;">s</div>	<p>Used hands to get up <input type="checkbox"/> 0 points</p> <p>Not completed in &lt; 60s <input type="checkbox"/> 0 points</p> <p>Time ≥ 16.70s <input type="checkbox"/> 1 point</p> <p>Time 13.70 – 16.69s <input type="checkbox"/> 2 points</p> <p>Time 11.20 – 13.69s <input type="checkbox"/> 3 points</p> <p>Time ≤ 11.19s <input type="checkbox"/> 4 points</p>

Was the measurement possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason: _____
Used hands to get up?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Total SPPB score:**   /12

### Balance tests eyes closed

**Note:** Perform these balance tests in the same way as the balance test in the SPPB protocol, but with the only difference that the eyes are closed

	Able to maintain for 10s	Seconds if not able to maintain for 10s	Number of trials (max of 3)
<u>Side-by-side stand 10s</u> Feet together side-by-side	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> , <input type="text"/> <input type="text"/> s	<input type="text"/>
<u>Semi-tandem stand 10s</u> Heel of one foot against side of big toe of the other	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> , <input type="text"/> <input type="text"/> s	<input type="text"/>
<u>Tandem stand 10s</u> Feet aligned heel to toe	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text"/> , <input type="text"/> <input type="text"/> s	<input type="text"/>

Was the measurement possible?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason: _____
-------------------------------	--

## Modified Minnesota Leisure Time Activities (MLTA) Questionnaire (Taylor, H. L et al., 1978)

Tell to the participant:

I am going to read a list of activities. Please tell me which activities you have done in the past two weeks.

I am going to read a list of activities. Please tell me which activities you have done in the past two weeks:			How often have you name the activity in the last two weeks?	What is the average amount of the time that you spent per session?		How many months per year do you name of activity?
	YES	NO	#times	# hours	#minutes	# months
Walking for exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>
Moderately strenuous household chores, for example scrubbing or vacuuming?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>
Mowing the lawn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>
Calisthenics/general exercising?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>
Gardening?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>
Golfing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/>

### The first Fried criteria for frailty

Did a participant have an unintentional loss of weight in previous year?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If yes, how much?	<input type="text" value=""/> <input type="text" value=""/> kg
Is unintentional loss of weight was more or equal to 4.5 kg or at least 5% of the previous year's body weight?	<input type="checkbox"/> YES <input type="checkbox"/> NO

## Fried criteria for frailty (Fried et al., 2001)

	Criteria																				
1. Shrinking, i.e. weight loss	Unintentional loss of 4.5 kg in the year before the current evaluation or unintentional weight loss of at least 5% of the previous year's body weight																				
2. Weakness, i.e. low handgrip strength	<p>Grip strength of the dominant hand (mean of 3 measurements), using a Jamar hand-held dynamometer:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">BMI/male</th> <th style="width: 25%;">Cutoff (kg)</th> <th style="width: 25%;">BMI/female</th> <th style="width: 25%;">Cutoff (kg)</th> </tr> </thead> <tbody> <tr> <td>≤24</td> <td>≤29</td> <td>≤23</td> <td>≤17</td> </tr> <tr> <td>24-26</td> <td>≤30</td> <td>23-26</td> <td>≤17.3</td> </tr> <tr> <td>26-28</td> <td>≤30</td> <td>26-29</td> <td>≤18</td> </tr> <tr> <td>&gt;28</td> <td>≤32</td> <td>&gt;29</td> <td>≤21</td> </tr> </tbody> </table>	BMI/male	Cutoff (kg)	BMI/female	Cutoff (kg)	≤24	≤29	≤23	≤17	24-26	≤30	23-26	≤17.3	26-28	≤30	26-29	≤18	>28	≤32	>29	≤21
BMI/male	Cutoff (kg)	BMI/female	Cutoff (kg)																		
≤24	≤29	≤23	≤17																		
24-26	≤30	23-26	≤17.3																		
26-28	≤30	26-29	≤18																		
>28	≤32	>29	≤21																		
3. Poor endurance, i.e. self-reported exhaustion	<p>Evaluation of two statements of the CES-D scale (in the self-administered part):</p> <p style="margin-left: 40px;">(a) I felt that everything I did was an effort</p> <p style="margin-left: 40px;">(b) I could not get going</p> <p>Criterion positive if at least one condition is present for 3 days or more during the last week.</p>																				
4. Slowness, i.e. low gait speed	<p>Cutoff for time to walk 4 m at usual pace (static protocol):</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Height/male (cm)</th> <th style="width: 25%;">Cutoff (m/s)</th> <th style="width: 25%;">Height/female (cm)</th> <th style="width: 25%;">Cutoff (m/s)</th> </tr> </thead> <tbody> <tr> <td>≤173</td> <td>≥0.65 m/s</td> <td>≤159</td> <td>≥0.65 m/s</td> </tr> <tr> <td>&gt;173</td> <td>≥0.76 m/s</td> <td>&gt;159</td> <td>≥0.76 m/s</td> </tr> </tbody> </table>	Height/male (cm)	Cutoff (m/s)	Height/female (cm)	Cutoff (m/s)	≤173	≥0.65 m/s	≤159	≥0.65 m/s	>173	≥0.76 m/s	>159	≥0.76 m/s								
Height/male (cm)	Cutoff (m/s)	Height/female (cm)	Cutoff (m/s)																		
≤173	≥0.65 m/s	≤159	≥0.65 m/s																		
>173	≥0.76 m/s	>159	≥0.76 m/s																		
5. Low activity, i.e. reduced energy consumption	Evaluation of the Modified Minnesota Leisure Time Physical Activity Questionnaire.																				

Criteria			
1. Shrinking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Poor endurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. Slowness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Low activity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Score:	<input type="checkbox"/> out of 5		
Result:	<ul style="list-style-type: none"> <li>• Frail: 3 or more criteria <input type="checkbox"/></li> <li>• Prefrail: 1 or 2 criteria <input type="checkbox"/></li> <li>• Not frail: 0 criteria <input type="checkbox"/></li> </ul>		

Dietary intake	
Is the food frequency questionnaire completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No, reason _____
Notes for food frequency questionnaire: <hr/> <hr/>	
<b>Macronutrients</b>  Energy: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> kcal  Fat: <input type="text"/> <input type="text"/> , <input type="text"/> g <input type="text"/> <input type="text"/> , <input type="text"/> en% Saturated fat: <input type="text"/> <input type="text"/> , <input type="text"/> g <input type="text"/> <input type="text"/> , <input type="text"/> en% Carbohydrates: <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> g <input type="text"/> <input type="text"/> , <input type="text"/> en% Protein: <input type="text"/> <input type="text"/> <input type="text"/> , <input type="text"/> g <input type="text"/> , <input type="text"/> g/kg/body weight Fibres: <input type="text"/> <input type="text"/> , <input type="text"/> g                    Salt <input type="text"/> <input type="text"/> , <input type="text"/> g	
<b>Minerals</b>  Sodium: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg                    Potassium: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg Calcium: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg                    Magnesium: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mg Iron: <input type="text"/> <input type="text"/> , <input type="text"/> mg                    Selenium: <input type="text"/> <input type="text"/> µg Zinc: <input type="text"/> <input type="text"/> , <input type="text"/> mg                    Iodine: <input type="text"/> <input type="text"/> <input type="text"/> µg	
<b>Vitamins</b>  Vitamin A: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> µg                    Vitamin D: <input type="text"/> , <input type="text"/> µg Vitamin E: <input type="text"/> <input type="text"/> , <input type="text"/> mg                    Vitamin B1: <input type="text"/> , <input type="text"/> <input type="text"/> mg Vitamin B2: <input type="text"/> , <input type="text"/> <input type="text"/> mg                    Vitamin B6: <input type="text"/> , <input type="text"/> <input type="text"/> mg Folic acid: <input type="text"/> <input type="text"/> <input type="text"/> µg                    Vitamin B12: <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> µg Vitamin B3: <input type="text"/> <input type="text"/> , <input type="text"/> mg                    Vitamin C: <input type="text"/> <input type="text"/> <input type="text"/> mg	
<b>Drinking fluids:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> ml	

## Standardised Mini-Mental State Examination (SMMSE)

Please see accompanying guide for directions for administration

**Say:** I am going to ask you some questions and give you some problems to solve. Please try to answer as best you can.

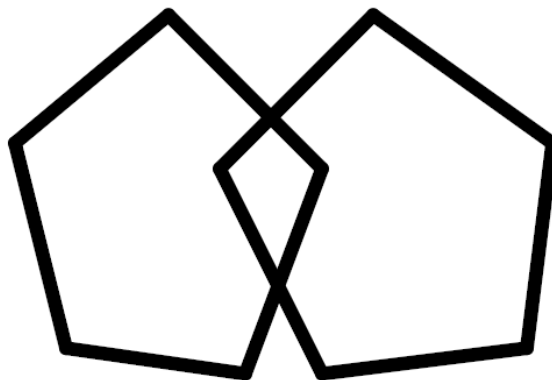
1.	(Allow 10 seconds for each reply). <b>Say:</b> a) What year is this? (Accept exact answer only) b) What season is this? (During the last week of the old season or first week of a new season, accept either) c) What month is this? (On the first day of a new month or the last day of the previous month, accept either) d) What is today's date? (Accept previous or next date) e) What day of the week is this? (Accept exact answer only)	/1 /1 /1 /1 /1
2.	(Allow 10 seconds for each reply). <b>Say:</b> a) What country are we in? (Accept exact answer only) b) What county are we in? (Accept exact answer only) c) What city/town are we in? (Accept exact answer only) d) (At home) What is the street address of this house? (Accept street name and house number or equivalent in rural areas) (In facility) What is the name of this building? (Accept exact name of institution only) e) (At home) What room are we in? (Accept exact answer only) (In facility) What floor of the building are we on? (Accept exact answer only)	/1 /1 /1 /1 /1
3.	<b>Say:</b> I am going to name three objects. When I am finished, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes (Say slowly at approximately one-second intervals). <b>Ball                      Car                      Man</b> For repeated use: Bell, jar, fan; bill, tar, can; bull, bar, pan <b>Say:</b> Please repeat the three items for me. (Score one point for each correct reply on the first attempt Allow 20 seconds for reply; if the person did not repeat all three, repeat until they are learned or up to a maximum of five times. (But only score first attempt).	/3
4.	<b>Spell the word WORLD.</b> (You may help the person to spell the word correctly) <b>Say:</b> Now spell it backwards please (Allow 30 seconds; if the subject cannot spell World even with assistance, score 0) Refer to accompanying guide for scoring instructions	/5
5.	<b>Say:</b> Now what were the three objects I asked you to remember? (Score one point for each correct answer regardless of order; allow 10 seconds)	/3
6.	Show wristwatch. <b>Ask:</b> <i>What is this called?</i> Score one point for correct response; accept "pencil" only; score 0 for pen; allow 10 seconds for reply)	/1
7.	Show pencil. <b>Ask:</b> <i>What is this called?</i> (Score one point for correct response; accept "pencil" only; score 0 for pen; allow 10 seconds for reply)	/1
8.	<b>Say:</b> I would like you to repeat a phrase after me: <i>No ifs, ands, or buts</i> (Allow 10 seconds for response. Score one point for a correct repetition. Must be exact, e.g. no ifs or buts, score 0)	/1
9.	<b>Say:</b> <i>Read the words on this page and then do what it says</i> Then, <b>hand</b> the person the sheet with CLOSE YOUR EYES (score on reverse of this sheet) on it. If the subject just reads and does not close eyes, you may repeat: Read the words on this page and then do what it says, (a maximum of three times. See point No. 3 in Directions for Administration section of accompanying guide). Allow 10 seconds, score one point only if the subject closes eyes. The subject does not have to read aloud.	/1
10.	<b>Hand</b> the person a pencil and paper. <b>Say:</b> <i>Write any complete sentence on that piece of paper.</i> (Allow 30 seconds. Score one point. The sentence must make sense. Ignore spelling errors).	/1
11.	<b>Place</b> design (see reverse of this sheet), pencil, eraser and paper in front of the person. <b>Say:</b> <i>Copy this design please.</i> Allow multiple tries. Wait until the person is finished and hands it back. Score one point for a correctly copied diagram. The person must have drawn a four-sided figure between two five-sided figures. Maximum time: One minute	/1
12.	<b>Ask</b> the person if he is right or left handed. <b>Take</b> a piece of paper, hold it up in front of the person and <b>say</b> the following: <i>Take this paper in your right/left hand (whichever is non-dominant), fold the paper in half once with both hands and put the paper down on the floor.</i>	
Takes paper in correct hand		/1
Folds it in half		/1
Puts it on the floor		/1
<b>TOTAL TEST SCORE:</b>		/30
ADJUSTED SCORE		/

Molloy DW, Alemayehu E, Roberts R. Reliability of a standardized Mini-Mental State Examination compared with the traditional Mini-Mental state Examination. *American Journal of Psychiatry*, Vol. 14, 1991a, pp.102-105. The Standardised Mini-Mental State Examination (SMMSE) is the copyright of Dr D.W. Molloy and may not be reproduced without the written consent of the author.

# Close your eyes

10. \_\_\_\_\_

\_\_\_\_\_



11. \_\_\_\_\_

Time: .....



## **PANINI Case Report Form**

### **Self-administered Tests**

1. Socio-demographic questions	
1.1 What is your country of origin?	_____
1.2 Do you speak a language other than English at home?	1. <input type="checkbox"/> No, English only 2. <input type="checkbox"/> Yes, please specify _____
1.3 What is your current marital status?	1. <input type="checkbox"/> Never married 2. <input type="checkbox"/> Married, since <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (year) 3. <input type="checkbox"/> Separated/ Divorced, since <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (year) 4. <input type="checkbox"/> Widowed, since <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (year)
2. Education	
2.1 What is the highest educational qualification you have completed?	1. <input type="checkbox"/> Primary education 2. <input type="checkbox"/> Secondary education 3. <input type="checkbox"/> Degree or diploma from a university 4. <input type="checkbox"/> Post graduate degree
2.2 How many years did you go to school?  (Counted from the beginning of primary school)	Total school years: <input type="text"/> <input type="text"/>
2.3 What was your main occupation before you retired?	_____

### 3. Social

<p>3.1 Who do you live with?</p> <p>(Please choose all that apply.)</p>	<p>1. <input type="checkbox"/> No one/ live alone</p> <p>2. <input type="checkbox"/> Partner/ spouse</p> <p>3. <input type="checkbox"/> Sibling(s) e.g. brother, sister</p> <p>4. <input type="checkbox"/> One or more children</p> <p>5. <input type="checkbox"/> Other, please specify</p> <p>_____</p>
<p>3.2 Where do you live?</p>	<p>1. <input type="checkbox"/> Home</p> <p style="padding-left: 20px;">a. <input type="checkbox"/> Privately owned</p> <p style="padding-left: 20px;">b. <input type="checkbox"/> Private rental</p> <p style="padding-left: 20px;">c. <input type="checkbox"/> Public rental</p> <p style="padding-left: 20px;">d. <input type="checkbox"/> Someone's else home</p> <p>2. <input type="checkbox"/> In aged care facility</p> <p>3. <input type="checkbox"/> In a serviced apartment / retirement village</p>
<p>3.3 Do you have a pet(s)?</p>	<p>1. <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes</p> <p style="padding-left: 20px;">a. <input type="checkbox"/> Dog</p> <p style="padding-left: 20px;">b. <input type="checkbox"/> Cat</p> <p style="padding-left: 20px;">c. <input type="checkbox"/> Bird</p> <p style="padding-left: 20px;">d. <input type="checkbox"/> Others, please specify</p> <p>_____</p> <p>_____</p>

#### 4. Alcohol, smoking, drugs

4.1 Do you currently drink alcohol?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes, (go to question 4.3) a. <input type="checkbox"/> Beer, quantity: _____ /week b. <input type="checkbox"/> Wine, quantity: _____ /week c. <input type="checkbox"/> Spirit, quantity: _____ /week d. <input type="checkbox"/> Others, please specify _____ quantity: _____ /week
4.2 Have you ever consumed alcohol?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes since: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (year) until: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (year) Type: _____, quantity: _____ per week
4.3 How many times a week do you drink alcohol in general?	1. <input type="checkbox"/> Daily 2. <input type="checkbox"/> Only on certain days of the week 3. <input type="checkbox"/> On special occasions
4.4 At what time of the day do you usually drink alcohol?	1. <input type="checkbox"/> Morning 2. <input type="checkbox"/> Afternoon 3. <input type="checkbox"/> Evening
4.5 Do you currently smoke?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes: (go to question 4.7) a. <input type="checkbox"/> cigarettes quantity: <input type="text"/> <input type="text"/> cigarettes/day since: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (year) b. <input type="checkbox"/> cigar c. <input type="checkbox"/> pipe

<p>4.6 Have you ever smoked?</p>	<p>1. <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes</p> <p style="padding-left: 40px;">since: <input type="text"/><input type="text"/><input type="text"/><input type="text"/> (year)</p> <p style="padding-left: 40px;">until: <input type="text"/><input type="text"/><input type="text"/><input type="text"/> (year)</p> <p style="padding-left: 40px;">quantity: <input type="text"/><input type="text"/> cigarettes/day</p>
<p>4.7 Do you use any illicit drugs?</p>	<p>1. <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes, please specify</p> <p>_____</p>

## 5 Mobility

Please consider your situation over the last 3 months.

<p>5.1 Do you have any problems with walking? (Types of problems you may have affecting your mobility could include shortness of breath, or pain, etc.)</p>	<p>1. <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes</p>
<p>5.2 Do you need something/someone to help you move around <i>indoors</i>?</p> <p>(Please choose all that apply.)</p>	<p>1. <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes,</p> <p style="margin-left: 40px;">a. <input type="checkbox"/> Walking holding someone's arm</p> <p style="margin-left: 40px;">b. <input type="checkbox"/> Walking holding furniture</p> <p style="margin-left: 40px;">b. <input type="checkbox"/> Walking stick</p> <p style="margin-left: 40px;">c. <input type="checkbox"/> Walking Frame (no wheels)</p> <p style="margin-left: 40px;">d. <input type="checkbox"/> Walking Frame (with wheels)</p> <p style="margin-left: 40px;">e. <input type="checkbox"/> Wheelchair</p> <p style="margin-left: 40px;">f. <input type="checkbox"/> Others, please specify _____</p>
<p>5.3 Do you need something/someone to help you move around <i>outdoors</i>?</p> <p>(Please choose all that apply.)</p>	<p>1. <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes,</p> <p style="margin-left: 40px;">a. <input type="checkbox"/> Walking holding someone's arm</p> <p style="margin-left: 40px;">b. <input type="checkbox"/> Walking holding furniture</p> <p style="margin-left: 40px;">b. <input type="checkbox"/> Walking stick</p> <p style="margin-left: 40px;">c. <input type="checkbox"/> Walking Frame (no wheels)</p> <p style="margin-left: 40px;">d. <input type="checkbox"/> Walking Frame (with wheels)</p> <p style="margin-left: 40px;">e. <input type="checkbox"/> Wheelchair</p> <p style="margin-left: 40px;">f. <input type="checkbox"/> Others, please specify _____</p>
<p>5.4 Do you use a mobility scooter?</p>	<p>1. <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes</p>
<p>5.5 Were you immobile or bedridden for longer than 1 week in the past 3 months?</p>	<p>1. <input type="checkbox"/> No</p> <p>2. <input type="checkbox"/> Yes</p>

5.6 Do you usually go outside every day?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes
5.7 Can you climb a flight of 10 stairs?	1. <input type="checkbox"/> Not anymore When did you stop doing that? <input type="text"/> <input type="text"/> months/years ago ( <i>please circle</i> ) 2. <input type="checkbox"/> Yes
5.8 Do you cycle?	1. <input type="checkbox"/> No, never 2. <input type="checkbox"/> Not anymore When did you stop doing that? <input type="text"/> <input type="text"/> months/years ago ( <i>please circle</i> ) 3. <input type="checkbox"/> Yes
5.9 Do you drive?	1. <input type="checkbox"/> No, never done it 2. <input type="checkbox"/> Not anymore When did you stop doing that? <input type="text"/> <input type="text"/> months/years ago ( <i>please circle</i> ) 3. <input type="checkbox"/> Yes
5.10 Do you travel on public transport on your own?	1. <input type="checkbox"/> No, never 2. <input type="checkbox"/> Not anymore When did you stop doing that? <input type="text"/> <input type="text"/> months/years ago ( <i>please circle</i> ) 3. <input type="checkbox"/> Yes
5.11 What is your highest level of physical fitness?	1. <input type="checkbox"/> Gymnastics / sports / gym / fitness 2. <input type="checkbox"/> Walking outdoors more than 20 minutes without a rest, at least 1 time per week 3. <input type="checkbox"/> Walking outdoors less than 20 minutes without a rest, at least 1 time per week 4. <input type="checkbox"/> Walking indoors 5. <input type="checkbox"/> Wheelchair bound / bedridden

5.12 What is your maximum walking distance?	1. <input type="checkbox"/> Over 1 kilometre 2. <input type="checkbox"/> Between 250 meters and 1 kilometre 3. <input type="checkbox"/> Less than 250 meters
---	--

6. Falls history	
6.1 Have you had any falls in the past year?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes, <input type="text"/> <input type="text"/> time(s)
6.2 In the past year were there any occasions when you almost fell?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes, <input type="text"/> <input type="text"/> time(s)
6.3 Do you have any concern with your standing balance?	1. <input type="checkbox"/> Never 2. <input type="checkbox"/> Sometimes 3. <input type="checkbox"/> Regularly 4. <input type="checkbox"/> Always
6.4 Do you get dizzy?	1. <input type="checkbox"/> Never 2. <input type="checkbox"/> Sometimes 3. <input type="checkbox"/> Regularly 4. <input type="checkbox"/> Always
6.5 Do you have a personal alarm?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes
6.6 Have you received any recent home modifications to make the environment safer for you?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes
6.7 Do you have any problems with your feet?	1. <input type="checkbox"/> Calluses (thickened hard skin) 2. <input type="checkbox"/> Bunions 3. <input type="checkbox"/> Ingrown toenails 4. <input type="checkbox"/> Tingling/ Numbness 5. <input type="checkbox"/> Pain

6.8 Do you cut your toenails by yourself?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes
6.9 Do you visit a podiatrist regularly for foot care?	1. <input type="checkbox"/> No 2. <input type="checkbox"/> Yes
6.10 What kind of footwear do you usually wear <i>indoor</i> ?	1. <input type="checkbox"/> Sandals 2. <input type="checkbox"/> Slippers 3. <input type="checkbox"/> Sport shoes 4. <input type="checkbox"/> Flats 5. <input type="checkbox"/> Boots 6. <input type="checkbox"/> Other, please specify _____
6.11 What kind of footwear do you usually wear <i>outdoor</i> ?	1. <input type="checkbox"/> Sandals 2. <input type="checkbox"/> Sport shoes 3. <input type="checkbox"/> Flats 4. <input type="checkbox"/> Boots 5. <input type="checkbox"/> Other, please specify _____
6.12 What kind of footwear did you wear when you last fell?	1. <input type="checkbox"/> Sandals 2. <input type="checkbox"/> Slippers 3. <input type="checkbox"/> Sport shoes 4. <input type="checkbox"/> Flats 5. <input type="checkbox"/> Boots 6. <input type="checkbox"/> Other, please specify _____

## Medications information

Are you currently taking any medications (prescription, over the counter, vitamins, minerals, supplements), or non-drug therapy?

#	Medication/ Non-drug Therapy	Indication	Dose (per admin)	Dose Units <sup>1</sup>	Frequency <sup>2</sup>	Route of Administration <sup>3</sup>	Taken regularly
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO
							<input type="checkbox"/> YES <input type="checkbox"/> NO

### Dose Units<sup>1</sup>

- 1 - g (gram)
- 2 - mg (milligram)
- 3 - µg (microgram)
- 4 - L (liter)
- 5 - mL (milliliter)
- 6 - IU (International Unit)
- 7 - Other

### Frequency<sup>2</sup>

- 1 - QD (once a day)
- 2 - BID (twice a day)
- 3 - TID (three times a day)
- 4 - QID (four times a day)
- 5 - QOD (every other day)
- 6 - QM (every month)
- 7 - QOM (every other month)
- 8 - QH (every hour)
- 9 - AC (before meals)
- 10 - PC (after meals)
- 11 - PRN (as needed)
- 12 - Other

### Route of Administration<sup>3</sup>

- 1 - Oral
- 2 - Topical
- 3 - Subcutaneous
- 4 - Intradermal
- 5 - Transdermal
- 6 - Intraocular
- 7 - Intramuscular
- 8 - Inhalation
- 9 - Intravenous
- 10 - Intraperitoneal
- 11 - Nasal
- 12 - Vaginal
- 13 - Rectal
- 14 - Other

## International Physical Activity Questionnaire Short Form (IPAQ, Both, M. L et al., 1999)

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. **Vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think *only* about those physical activities that you did for at least 10 minutes at a time.

1. During the **last 7 days**, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling?

\_\_\_\_\_ **days per week**

☐

No vigorous physical activities

➔ **Skip to question 3**

2. How much time did you usually spend doing **vigorous** physical activities on one of those days?

\_\_\_\_\_ **hours per day**

\_\_\_\_\_ **minutes per day**

☐

Don't know/Not sure

Think about all the **moderate** activities that you did in the **last 7 days**. **Moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think *only* about those physical activities that you did for at least 10 minutes at a time.

3. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

\_\_\_\_\_ **days per week**

☐

No moderate physical activities

➔ **Skip to question 5**

4. How much time did you usually spend doing **moderate** physical activities on one of those days?

\_\_\_\_\_ **hours per day**

\_\_\_\_\_ **minutes per day**

☐

Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you have done solely for recreation, sport, exercise, or leisure.

5. During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

\_\_\_\_\_ **days per week**

☐

No walking      ➡ *Skip to question 7*

6. How much time did you usually spend **walking** on one of those days?

\_\_\_\_\_ **hours per day**

\_\_\_\_\_ **minutes per day**

☐

Don't know/Not sure

The last question is about the time you spent **sitting** on weekdays during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the **last 7 days**, how much time did you spend **sitting** on a **week day**?

\_\_\_\_\_ **hours per day**

\_\_\_\_\_ **minutes per day**

☐

Don't know/Not sure

**Short Fall Efficacy Scale International (FES-I, Kempen, G. I et al., 2008)**

Now we would like to ask some questions about how concerned you are about the possibility of falling. Please reply thinking about how you usually do the activity. If you currently do not do the activity, please answer to show whether you think you would be concerned about falling IF you did the activity. For each of the following activities, please tick the box which is closest to your own opinion to show how concerned you are that you might fall IF you did this activity.

		Not at all concerned 1	Somewhat concerned 2	Fairly concerned 3	Very concerned 4
1	Getting dressed or undressed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2	Taking a bath or shower	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3	Getting in or out of a chair	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4	Going up or down stairs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5	Reaching for something above your head or on the ground	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6	Walking up or down a slope	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7	Going out to a social event (e.g. religious service, family gathering or club meeting)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

**Katz Index of Independence in Activities of Daily Living (Katz ADL, Katz, 1983)**

Activity	Independent
	ANSWER
1. Bathing (sponge bath, tub bath, or shower) Receives either no assistance or assistance in bathing only one part of body	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Dressing Gets clothes and dresses without any assistance except for tying shoes	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Toileting Goes to toilet room, uses toilet, arranges clothes, and returns without any assistance (may use cane or walker for support and may use bedpan/urinal at night)	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Transferring Moves in and out of bed and chair without assistance (may use can or walker)	<input type="checkbox"/> YES <input type="checkbox"/> NO
5. Continence Controls bowel and bladder completely by self (without occasional "accidents")	<input type="checkbox"/> YES <input type="checkbox"/> NO
6. Feeding Feeds self without assistance (except for help with cutting meat or buttering bread)	<input type="checkbox"/> YES <input type="checkbox"/> NO

### Geriatric Depression Scale (GDS-15, Sheikh & Yesavage 1986)

Choose the best answer for how you felt **over the past week**:

Question	Answer	Score
1. Are you basically satisfied with your life?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
2. Have you dropped many of your activities and interests?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
3. Do you feel that your life is empty?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
4. Do you often get bored?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
5. Are you in good spirits most of the time?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
6. Are you afraid that something bad is going to happen to you?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
7. Do you feel happy most of the time?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
8. Do you often feel helpless	<input type="checkbox"/> YES <input type="checkbox"/> NO	
9. Do you prefer to stay at home, rather than going out and doing new things?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
10. Do you feel you have more problems with memory than most?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
11. Do you think it is wonderful to be alive now?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
12. Do you feel pretty worthless the way you are now?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
13. Do you feel full of energy?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
14. Do you feel that your situation is hopeless?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
15. Do you think that most people are better off than you are?	<input type="checkbox"/> YES <input type="checkbox"/> NO	

### Center for Epidemiologic Studies Depression Scale (CES-D) (adapted)

Instructions: Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way **during the past week**.

	Rarely or none of the time (less than 1 day)	Some or a little of the time 1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
I felt that everything I did was an effort				
I could not get going				

## **Food Frequency Questionnaire (EPIC, 1997)**

This questionnaire asks for some background information about you, especially about what you eat.

Please answer every question. If you are uncertain about how to answer a question then do the best you can, but please do not leave a question blank.

# 1. YOUR DIET LAST YEAR

For each food there is an amount shown, either a "medium serving" or a common household unit such as a slice or teaspoon. Please put a tick (✓) in the box to indicate how often, on average, you have eaten the specified amount of each food **during the past year**.

## EXAMPLES

For white bread the amount is one slice, so if you ate 4 or 5 slices a day, you should put a tick in the column headed "4-5 per day".

FOODS AND AMOUNTS	AVERAGE USE LAST YEAR								
BREAD AND SAVOURY BISCUITS (one slice or biscuit)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+per day
White bread and rolls								✓	

For chips, the amount is a "medium serving", so if you had a helping of chips twice a week you should put a tick in the column headed "2-4 per week".

FOODS AND AMOUNTS	AVERAGE USE LAST YEAR								
POTATOES, RICE AND PASTA (medium serving)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+per day
Chips				✓					

For very seasonal fruit such as strawberries and raspberries you should estimate your average use when the fruits are in season, so if you ate strawberries or raspberries about once a week when they were in season you should put a tick in the column headed "once a week".

FOODS AND AMOUNTS	AVERAGE USE LAST YEAR								
FRUIT (1 fruit or medium serving)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+per day
Strawberries, raspberries, kiwi fruit			✓						

Please estimate your average food use as best you can, and please answer every question - do not leave ANY lines blank.

**PLEASE PUT A TICK (✓) ON EVERY LINE**

FOODS AND AMOUNTS	AVER AGE USE LAST YEAR								
MEAT AND FISH (medium serving)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Beef: roast, steak, mince, stew or casserole									
Beefburgers									
Pork: roast, chops, stew or slices									
Lamb: roast, chops or stew									
Chicken or other poultry e.g. turkey									
Bacon									
Ham									
Corned beef, Spam, luncheon meats									
Sausages									
Savoury pies, e.g. meat pie, pork pie, pasties, steak & kidney pie, sausage rolls									
Liver, liver pâté, liver sausage									
Fried fish in batter, as in fish and chips									
Fish fingers, fish cakes									
Other white fish, fresh or frozen, e.g. cod, haddock, plaice, sole, halibut									
Oily fish, fresh or canned, e.g. mackerel, kippers, tuna, salmon, sardines, herring									
Shellfish, e.g. crab, prawns, mussels									
Fish roe, taramasalata									
	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day

**Please check that you have a tick (✓) on EVERY line**

**PLEASE PUT A TICK (✓) ON EVERY LINE**

FOODS AND AMOUNTS	AVERAGE USE LAST YEAR									
BREAD AND SAVOURY BISCUITS (one slice or biscuit)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day	
White bread and rolls										
Brown bread										
Wholemeal bread and rolls										
Cream crackers, cheese biscuits										
Crispbread, e.g. Ryvita										
<b>CEREALS</b> (one bowl)										
Porridge, Readybrek										
Breakfast cereal such as cornflakes , muesli etc.										
<b>POTATOES, RICE AND PASTA</b> (medium serving)										
Boiled, mashed, instant or jacket potatoes										
Chips										
Roast potatoes										
Potato salad										
White rice										
Brown rice										
White or green pasta, e.g. spaghetti , macaroni, noodles										
Wholemeal pasta										
Lasagne, moussaka										
Pizza										
	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day	

**Please check that you have a tick (✓) on EVERY line**

PLEASE PUT A TICK (✓) ON EVERY LINE

FOODS AND AMOUNTS	AVERAGE USE LAST YEAR								
DAIRY PRODUCTS AND FATS	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Single or sour cream (tablespoon)									
Double or clotted cream (tablespoon)									
Low fat yogurt, fromage frais (125g carton)									
Full fat or Greek yogurt (125g carton)									
Dairy desserts (125g carton)									
Cheese, e.g. Cheddar, Brie, Edam (medium serving)									
Cottage cheese, low fat soft cheese (medium serving)									
Eggs as boiled, fried, scrambled, etc. (one)									
Quiche (medium serving)									
Low calorie, low fat salad cream (tablespoon)									
Salad cream, mayonnaise (tablespoon)									
French dressing (tablespoon)									
Other salad dressing (tablespoon)									
<b>The following on bread or vegetables</b>									
Butter (teaspoon)									
Block margarine, e.g. Stork, Krona (teaspoon)									
Polyunsaturated margarine (tub), e.g. Flora, sunflower (teaspoon)									
Other soft margarine, dairy spreads (tub), e.g. Blue Band, Clover (teaspoon)									
Low fat spread (tub), e.g. Outline, Gold (teaspoon)									
Very low fat spread (tub) (teaspoon)									
	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day

Please check that you have a tick (✓) on EVERY line

**PLEASE PUT A TICK (✓) ON EVERY LINE**

FOODS AND AMOUNTS	AVERAGE USE LAST YEAR								
SWEETS AND SNACKS (medium serving)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Sweet biscuits, chocolate , e.g. digestive (one)									
Sweet biscuits, plain, e.g. Nice, ginger(one)									
Cakes e.g. fruit, sponge , home baked									
Cakes e.g. fruit, sponge, ready made									
Buns, pastries e.g. scones, flapjacks, home baked									
Buns, pastries e.g. croissants, doughnuts, ready made									
Fruit pies, tarts, crumbles, home baked									
Fruit pies, tarts, crumbles, ready made									
Sponge puddings, home baked									
Sponge puddings, ready made									
Milk puddings, e.g. rice, custard, trifle									
Ice cream, choc-ices									
Chocolates, single or squares									
Chocolate snack bars e.g. Mars, Crunchie									
Sweets, toffees, mints									
Sugar added to tea, coffee, cereal (teaspoon)									
Crisps or other packet snacks, e.g. Wotsits									
Peanuts or other nuts									
<b>SOUPS, SAUCES, AND SPREADS</b>									
Vegetable soups (bowl)									
Meat soups (bowl)									
Sauces, e.g. white sauce, cheese sauce, gravy (tablespoon)									
Tomato ketchup (tablespoon)									
Pickles, chutney (tablespoon)									
Marmite, Bovril (teaspoon)									
Jam, marmalade , honey (teaspoon)									
Peanut butter (teaspoon)									
	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day

**Please check that you have a tick (✓) on EVERY line**

PLEASE PUT A TICK (✓) ON EVERY LINE

FOODS AND AMOUNTS	AVERAGE USE LAST YEAR								
<b>DRINKS</b>	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Tea (cup)									
Coffee, instant or ground (cup)									
Coffee, decaffeinated (cup)									
Coffee whitener, e.g. Coffee-mate (teaspoon)									
Cocoa, hot chocolate (cup)									
Horlicks, Ovaltine (cup)									
Wine (glass)									
Beer, lager or cider (half pint)									
Port, sherry, vermouth, liqueurs (glass)									
Spirits, e.g. gin, brandy, whisky, vodka (single)									
Low calorie or diet fizzy soft drinks (glass)									
Fizzy soft drinks, e.g. Coca cola, lemonade (glass)									
Pure fruit juice (100%) e.g. orange, apple juice (glass)									
Fruit squash or cordial (glass)									
<b>FRUIT</b>									
<b>For seasonal fruits marked *, please estimate your average use when the fruit is in season</b>									
Apples (1 fruit)									
Pears (1 fruit)									
Oranges, satsumas, mandarins (1 fruit)									
Grapefruit (half)									
Bananas (1 fruit)									
Grapes (medium serving)									
Melon (1 slice)									
* Peaches, plums, apricots (1 fruit)									
* Strawberries, raspberries, kiwi fruit (medium serving)									
Tinned fruit (medium serving)									
Dried fruit, e.g. raisins, prunes (medium serving)									
	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day

Please check that you have a tick (✓) on EVERY line

PLEASE PUT A TICK (✓) ON EVERY LINE

FOODS AND AMOUNTS	AVERAGE USE LAST YEAR									
VEGETABLES Fresh, frozen or tinned (medium serving)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day	
Carrots										
Spinach										
Broccoli, spring greens, kale										
Brussels sprouts										
Cabbage										
Peas										
Green beans, broad beans, runner beans										
Marrow, courgettes										
Cauliflower										
Parsnips, turnips, swedes										
Leeks										
Onions										
Garlic										
Mushrooms										
Sweet peppers										
Beansprouts										
Green salad, lettuce, cucumber, celery										
Watercress										
Tomatoes										
Sweetcorn										
Beetroot										
Coleslaw										
Avocado										
Baked beans										
Dried lentils, beans, peas										
Tofu , soya meat, TVP, Vegeburger										
	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day	

Please check that you have a tick (✓) on EVERY line

YOUR DIET LAST YEAR, continued

2. Are there any OTHER foods which you ate more than once a week? ☐ Yes ☐ No  
If yes, please list below

Food	Usual serving size	Number of times eaten each week

3. What type of milk did you most often use?  
Select one only
- |                      |                          |                         |                          |
|----------------------|--------------------------|-------------------------|--------------------------|
| Fullcream, silver    | <input type="checkbox"/> | Semi-skimmed, red/white | <input type="checkbox"/> |
| Skimmed/ blue        | <input type="checkbox"/> | Channel Islands, gold   | <input type="checkbox"/> |
| Dried milk           | <input type="checkbox"/> | Soya                    | <input type="checkbox"/> |
| Other, specify _____ |                          | None                    | <input type="checkbox"/> |

4. How much milk did you drink each day, including milk with tea, coffee, cereals etc.?
- |                   |                          |                          |                          |
|-------------------|--------------------------|--------------------------|--------------------------|
| None              | <input type="checkbox"/> | Three quarters of a pint | <input type="checkbox"/> |
| Quarter of a pint | <input type="checkbox"/> | One pint                 | <input type="checkbox"/> |
| Half a pint       | <input type="checkbox"/> | More than one pint       | <input type="checkbox"/> |

5. Did you usually eat breakfast cereal (excluding porridge and Ready Brek mentioned earlier)? ☐ Yes ☐ No

If yes, which brand and type of breakfast cereal, including muesli, did you usually eat?  
List the one or two types most often used

Brand e.g. Kellogg's	Type e.g. cornflakes
_____	_____
_____	_____

6. What kind of fat did you most often use for frying, roasting, grilling etc.?  
Select one only
- |                |                          |                     |                          |
|----------------|--------------------------|---------------------|--------------------------|
| Butter         | <input type="checkbox"/> | Solid vegetable fat | <input type="checkbox"/> |
| Lard/ dripping | <input type="checkbox"/> | Margarine           | <input type="checkbox"/> |
| Vegetable oil  | <input type="checkbox"/> | None                | <input type="checkbox"/> |
- If you used vegetable oil, please give type e.g. corn, sunflower \_\_\_\_\_

7. What kind of fat did you most often use for baking cakes etc.?  
Select one only
- |                |                          |                     |                          |
|----------------|--------------------------|---------------------|--------------------------|
| Butter         | <input type="checkbox"/> | Solid vegetable fat | <input type="checkbox"/> |
| Lard/ dripping | <input type="checkbox"/> | Margarine           | <input type="checkbox"/> |
| Vegetable oil  | <input type="checkbox"/> | None                | <input type="checkbox"/> |
- If you used vegetable oil, please give name or type e.g. Flora, Stork \_\_\_\_\_

YOUR DIET LAST YEAR, continued

8.

How often did you eat food that was fried at home?

Daily ☐

1-3 times a week ☐

4-6 times a week ☐

Less than once a week ☐

Never ☐
9.

How often did you eat fried food away from home?

Daily ☐

1-3 times a week ☐

4-6 times a week ☐

Less than once a week ☐

Never ☐
10.

What did you do with the visible fat on your meat?

Ate most of the fat ☐

Ate as little as possible ☐

Ate some of the fat ☐

Did not eat meat ☐
11.

How often did you eat grilled or roast meat?

\_\_\_\_\_ times a week
12.

How well cooked did you usually have grilled or roast meat?

Well done /dark brown ☐

Lightly cooked/ rare ☐

Medium ☐

Did not eat meat ☐
13.

How often did you add salt to food while cooking?

Always ☐

Rarely ☐

Usually ☐

Never ☐

Sometimes ☐
14.

How often did you add salt to food at the table?

Always ☐

Rarely ☐

Usually ☐

Never ☐

Sometimes ☐
15.

Did you regularly use a salt substitute (e.g. LoSalt)?

☐ Yes

☐ No

If yes, which brand? \_\_\_\_\_
16.

During the course of last year, on average, how many times a week did you eat the following foods?

Food type	Times/ week	Portion size
Vegetables (not including potatoes)	_____	Medium serving
Salads	_____	Medium serving
Fruit and fruit products (not including fruit juice)	_____	Medium serving or 1 fruit
Fish and fish products	_____	Medium serving
Meat, meat products and meat dishes (including bacon, ham and chicken)	_____	Medium serving

17. Have you taken any vitamins, minerals, fish oils, fibre or other food supplements during the past year?

Yes ☐ No ☐ Don't know ☐

If yes, please complete the table below. If you have taken more than 5 types of supplement please put the most frequently consumed brands first.

Vitamin supplements	Average frequency									
	Tick one box per line to show how often on average you consumed supplements									
Name and brand Please list full name, brand and strength	Dose Please state number of pills, capsules or teaspoons consumed	Never or less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day

Thank you for your help!

### Self-administered questionnaires- information

How were the self-administered questionnaires completed?

☐ by participant

☐ by assessor

### Additional question for water consumption

Total amount of water consumed  ml in a day

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