

File No: _____
 Name: _____
 DOB: ____/____/____ Sex: M / F
 Address: _____
 Phone: _____













SEARCH





Self-Assessed Report of Personal Capacity & Healthy Ageing

The SEARCH is an assessment of personal capacity and health using self-reported questions. Tick the responses the best fit each question. Deficits identified in SEARCH can be used to calculate a frailty index. Refer to scoring at end of questionnaire for frailty classification. The completed questionnaire should be returned to a health professional for review and to develop a health and wellbeing management plan.

Date:

Questions	Tick Responses to Each Question	Score
NUTRITIONAL STATUS		
 Has your <u>food intake decreased</u> over the last 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?	<input type="checkbox"/> No	0
	<input type="checkbox"/> Yes	1
Have you <u>lost more than 3kg in weight</u> over the last 3 months?	<input type="checkbox"/> No	0
	<input type="checkbox"/> Yes	1
	<input type="checkbox"/> Don't know	1
ORAL HEALTH		
 Have you had any <u>pain</u> in your <u>mouth</u> while <u>chewing</u> ?	<input type="checkbox"/> No	0
	<input type="checkbox"/> Yes	1
Have you had to interrupt meals because of problems with <u>poorly fitting dentures</u> , <u>not enough teeth</u> or a <u>dry mouth</u> ?	<input type="checkbox"/> No	0
	<input type="checkbox"/> Yes	1
FATIGUE		
 During the past week, how often have you felt that <u>everything was an effort</u> ?	<input type="checkbox"/> Rarely	0
	<input type="checkbox"/> Occasional amount	0.5
	<input type="checkbox"/> Most of the time	1
During the past week, how often have you felt you <u>could not get going</u> ?	<input type="checkbox"/> Rarely	0
	<input type="checkbox"/> Occasional amount	0.5
	<input type="checkbox"/> Most of the time	1
During your waking time, how often do you feel <u>tired</u> or <u>fatigued</u> ?	<input type="checkbox"/> Rarely	0
	<input type="checkbox"/> Occasional amount	0.5
	<input type="checkbox"/> Most of the time	1
During the past month how would you rate your <u>sleep</u> quality overall?	<input type="checkbox"/> Good	0
	<input type="checkbox"/> Bad	1
PAIN		
 How much <u>bodily pain</u> have you had during the past four weeks?	<input type="checkbox"/> None or mild	0
	<input type="checkbox"/> Moderate	0.5
	<input type="checkbox"/> Severe	1
Foot pain. I have <u>pain in my feet</u> .	<input type="checkbox"/> Rarely	0
	<input type="checkbox"/> Occasional amount	0.5
	<input type="checkbox"/> Most of the time	1

	Questions	Tick Responses	Score
	PHYSICAL ACTIVITY		
	During the last 7 days, how much time did you spend <u>sitting</u> during the day?	<input type="checkbox"/> Some of the day <input type="checkbox"/> Most of the day <input type="checkbox"/> All day	0 0.5 1
	During the last 7 days, on how many days did you <u>walk for at least 10 minutes</u> at a time?	<input type="checkbox"/> Most days (5-7 days) <input type="checkbox"/> Some days (2-4 days) <input type="checkbox"/> Rarely or not at all	0 0.5 1
	During the last 7 days, on how many days did you do <u>moderate physical activities</u> like gardening, cleaning, bicycling at a regular pace, swimming or other fitness activities?	<input type="checkbox"/> Most days (5-7 days) <input type="checkbox"/> Some days (2-4 days) <input type="checkbox"/> Rarely or not at all	0 0.5 1
	STRENGTH		
	Do you experience problems in your daily life due to <u>weakness</u> in your <u>hands</u> ?	<input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Yes	0 0.5 1
	Do you experience problems in your daily life due to <u>weakness</u> in your <u>legs</u> or <u>feet</u> ?	<input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Yes	0 0.5 1
	WALKING SPEED		
	Which of the following best describes your <u>walking speed</u> ?	<input type="checkbox"/> Normal or brisk <input type="checkbox"/> Stroll at an easy pace <input type="checkbox"/> Very slow / unable to walk	0 0.5 1
	Does your health limit you <u>walking 100 metres</u> ?	<input type="checkbox"/> No <input type="checkbox"/> Yes, limited a little <input type="checkbox"/> Yes, limited a lot	0 0.5 1
	Does your health limit you <u>walking more than one kilometre</u> ?	<input type="checkbox"/> No <input type="checkbox"/> Yes, limited a little <input type="checkbox"/> Yes, limited a lot	0 0.5 1
	FALLS & BALANCE		
	How many <u>falls</u> (including slips trips and falls to the ground) did you have in the past year?	<input type="checkbox"/> No falls <input type="checkbox"/> 1 fall <input type="checkbox"/> 2 or more falls	0 0.5 1
	Do you have any problems keeping your <u>balance</u> ?	<input type="checkbox"/> No <input type="checkbox"/> Yes	0 1
	URINARY CONTINENCE		
	During the last 3 months, have you <u>leaked urine</u> (even a small amount)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	0 1
	MEMORY		
	How would you rate your <u>memory</u> overall?	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	0 0.5 1

	Questions	Tick Responses	Score									
	MENTAL HEALTH											
	Over the past 2 weeks have you been bothered by feeling <u>nervous, anxious, or on edge</u> ?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More days than not	0 0.5 1									
	Over the past 2 weeks have you been bothered by not being able to stop or control <u>worrying</u> ?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More days than not	0 0.5 1									
	Over the past 2 weeks have you been bothered by feeling <u>down, depressed, or hopeless</u> ?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More days than not	0 0.5 1									
	Over the past 2 weeks have you been bothered by <u>little interest or pleasure in doing things</u> ?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More days than not	0 0.5 1									
	MULTIPLE MEDICATIONS											
	How many different doctor-ordered (prescription) <u>medications</u> do you take?	<input type="checkbox"/> 0-4 <input type="checkbox"/> 5 or more	0 1									
	HEALTH CONDITIONS As far as you know, do you have any of the following health conditions at the present time?		Number of conditions /10									
	<input type="checkbox"/> Heart trouble (such as angina, congestive heart failure, or coronary artery disease) <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Digestive problems (such as ulcer, colitis, or gallbladder disease) <input type="checkbox"/> Asthma, emphysema or chronic bronchitis	<input type="checkbox"/> Arthritis or rheumatism <input type="checkbox"/> Liver problems (such as cirrhosis) <input type="checkbox"/> Kidney disease <input type="checkbox"/> Cancer diagnosed in the past 3 years <input type="checkbox"/> Other										
	In general, would you say your <u>health</u> is:	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		0 0.5 1								
	SENSORY											
	Vision. In the past month, how much has your <u>eyesight</u> interfered with your life in general?	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> A fair amount	0 0.5 1									
	Hearing. In the past month, how much has your <u>hearing</u> interfered with your life in general?	<input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> A fair amount	0 0.5 1									
SEARCH Score – TOTAL:			/ 40									
SEARCH-Plan A SEARCH-plan should be developed for any capacity or health deficits identified above. Priorities for intervention should be identified and recommendations documented.		<table border="1"> <thead> <tr> <th>Score</th> <th>Frailty Status (% deficits)</th> </tr> </thead> <tbody> <tr> <td>0 – 3.5</td> <td><input type="checkbox"/> Non-frail (0 to ≤10%)</td> </tr> <tr> <td>4.0 – 8.0</td> <td><input type="checkbox"/> Vulnerable (>10 to ≤21%)</td> </tr> <tr> <td>8.5 -17.5</td> <td><input type="checkbox"/> Frail (>21 to <45%)</td> </tr> <tr> <td>18 +</td> <td><input type="checkbox"/> Severely Frail (≥45%)</td> </tr> </tbody> </table>	Score	Frailty Status (% deficits)	0 – 3.5	<input type="checkbox"/> Non-frail (0 to ≤10%)	4.0 – 8.0	<input type="checkbox"/> Vulnerable (>10 to ≤21%)	8.5 -17.5	<input type="checkbox"/> Frail (>21 to <45%)	18 +	<input type="checkbox"/> Severely Frail (≥45%)
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