

Kihon Checklist

No.	Questions	Answer	
1	Do you go out by bus or train by yourself?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
2	Do you go shopping to buy daily necessities by yourself?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
3	Do you manage your own deposits and savings at the bank?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
4	Do you sometimes visit your friends?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
5	Do your family or friends turn to you for advice?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
6	Do you normally climb stairs without using handrail or wall for support?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
7	Do you normally stand up from a chair without any aids?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
8	Do you normally walk continuously for 15 minutes?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
9	Have you experienced a fall in the past year?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
10	Do you have a fear of falling while walking?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
11	Have you lost 2kg or more in the past 6 months?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
12	Height: cm, Weight: kg, BMI: kg/m ² If BMI is less than 18.5, this item is	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
13	Do you have any difficulties eating tough foods compared to 6 months ago?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
14	Have you choked on your tea or soup recently?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
15	Do you often experience having a dry mouth?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
16	Do you go out at least once a week?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
17	Do you go out less frequently compared to last year?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
18	Do your family or your friends point out your memory loss? e.g."You ask the same question over and over again."	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
19	Do you make a call by looking up phone numbers?	<input type="checkbox"/> 0. YES	<input type="checkbox"/> 1. NO
20	Do you find yourself not knowing today's date?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
21	In the last 2 weeks have you felt a lack of fulfillment in your daily life?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
22	In the last 2 weeks have you felt a lack of joy when doing the things you used to enjoy?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
23	In the last 2 weeks have you felt difficulty in doing what you could do easily before?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
24	In the last 2 weeks have you felt helpless?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO
25	In the last 2 weeks have you felt tired without a reason?	<input type="checkbox"/> 1. YES	<input type="checkbox"/> 0. NO

(Working Group on Frailty in JGS)