[Program Name] Participant Information Form

Admin Use Only: ***Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.
State abbreviation: __ __ (e.g., NY, VA, etc.)
First four letters of the site name: __ __ __ __
Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)
Participant number: __ __ (e.g., 01, 02, 03, etc.)

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1. Did your doctor or other health care provider suggest that you attend this program O Yes O No

2. How old are you today? ____________years

3. Do you live alone? O Yes O No

4. Are you: O Male O Female O Prefer Not to Say?

5. Are you of Hispanic, Latino, or Spanish origin? O Yes O No

6. What is your race? **Check all that apply**.
   O American Indian or Alaska Native
   O Black or African American
   O Asian
   O Native Hawaiian or other Pacific Islander
   O White

7. What is the highest grade or level of school that you have completed?
   O some elementary, middle, or high school
   O high school graduate or GED
   O some college or technical school
   O college (4 years or more)

8. Have you ever served in the military? O Yes O No

9. In general, would you say that your health is:
   ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

10. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)? **Check Yes or No.**

	YES	NO		YES	NO
Anxiety Disorder			Chronic Pain		
High Cholesterol			Kidney Disease		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Obesity		
Hypertension (High Blood Pressure)			Schizophrenia or Other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Arthritis/Rheumatic Disease		
Heart Disease			Alzheimer’s Disease or other dementia		
Parkinson’s Disease			Traumatic Brain Injury		
Other Chronic Condition					

Please turn this paper over and fill out the other side.

11. Are you limited in any way in any activities because of physical, mental, or emotional problems?
    O Yes   O No

12. How often do you feel lonely or isolated from those around you?
    O Never   O Rarely   O Sometimes   O Often   O Always

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

13. In the past 3 months, how many times have you fallen? O none   O ________times

    If you fell in the past 3 months:

    a. how many of these falls caused an injury? *(By an injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor.*
       _______number of falls causing an injury

    b. Did you tell anyone, such as a family member, friend, or healthcare provider about this fall, whether or not it resulted in an injury? O Yes   O No

    c. what happened after you fell? *(Please check all that apply)*
       ○ Went to the Emergency Room   ○ Was admitted to the hospital
       ○ Visited my Primary Care Physician   ○ Did not seek medical care _______

14. How fearful are you of falling?   O Not at all   O A little   O Somewhat   O A lot

15. Please mark the circle that tells us how sure you are that you can do the following activities.

How sure are you that:

	Not at all sure	**Somewhat sure**	**Neutral**	**Sure**	**Very Sure**
a. I can find a way to get up if I fall	O	O	O	O	O
b. I can find a way to reduce falls	O	O	O	O	O
c. I can increase my flexibility	O	O	O	O	O
d. I can increase my physical strength	O	O	O	O	O
e. I can become more steady on my feet	O	O	O	O	O

18. During the <u>last 4 weeks</u>, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups?

    ○ Not at all   ○Slightly   ○Moderately   ○Quite a bit   ○ Extremely

19. I have made safety modifications in my home, such as installing grab bars or securing loose rugs, to reduce my risk of falling   O True   O False

20. What best describes your activity level?
    O Vigorously active for at least 30 min, 3 times per week
    O Moderately active at least 3 times per week
    O Seldom active, preferring sedentary activities