[Program Name] Participant Post Program Survey

Today's date: ____/ ____/________
M M D D Y Y Y Y

Participant I.D. (first two letters of your first name, first two letters of last name, last two numbers of your birth year): __ __ __ __ __ __

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1. In general, would you say that your health is:

   ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

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.

2. Since this program began, how many times have you fallen? O none O _______times

   a. If you fell since this program began, 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

3. How fearful are you of falling?

   ○ Not at all ○ A little ○ Somewhat ○ A lot

4. Has this program reduced your fear of falling? O Yes O No

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

How sure are you that:	Very sure	Sure	Somewhat sure	Not at all sure
a. I can find a way to get up if I fall	○	○	○	○
b. I can find a way to reduce falls	○	○	○	○
c. I can protect myself if I fall	○	○	○	○
d. I can increase my physical strength	○	○	○	○
e. I can become more steady on my feet	○	○	○	○

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

Participant Post Program Survey (continued)

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

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

7. Please tell us your thoughts about this program. **Check one circle for each question**.

As a result of this program:	Strongly Agree	Agree	Disagree	Strongly Disagree
a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling	O	O	O	O
b. I feel more comfortable talking to my family and friends about falling	O	O	O	O
c. I feel more comfortable increasing my activity	O	O	O	O
d. I plan to continue exercising	O	O	O	O
e. I feel more satisfied with my life	O	O	O	O
f. I would recommend this program to a friend or relative	O	O	O	O

8. Since this program began, what have you done to reduce your chance of a fall? **Check all that apply.**

   O Talked to a family member or friend about how I can reduce my risk of falling

   O Talked to a health care provider about how I can reduce my risk of falling

   O Had my vision checked

   O Had my medications reviewed by a health care provider or pharmacist

   O Participated in another fall prevention program in my community

   O Did exercises I learned in this program at home

   O Made changes in my home to reduce my risk of falling (for example, secured rugs or improved lighting)