[Program Name] Participant Information Form

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 your last name, last two numbers of your birth year): __ __ __ __ __ __

---

1. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?

   O Yes O No

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

   ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

3. How old are you today? _____years

4. Do you live alone? O Yes O No

5. Are you: O Male or O Female ?

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

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

8. What is the highest grade or level of school that you have completed?
   - O Less than high school
   - O Some high school
   - O High school graduate or GED
   - O Some college or vocational school
   - O College graduate or higher

9. Are you limited in any way in any activities because of physical, mental, or emotional problems?

   O Yes O No

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

Participant Information Form (continued)

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.

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

    a. If you fell in the past 3 months, 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

11. How fearful are you of falling?

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

12. 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	○	○	○	○

13. 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

14. 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)? (**Please check all that apply**.)

    ☐ Arthritis or other bone/joint disease
    ☐ Heart disease or blood circulation problem
    ☐ Breathing/lung disease
    ☐ Glaucoma/ other chronic eye problem
    ☐ Depression
    ☐ Other chronic condition: _____
    ☐ Diabetes
    ☐ None (No chronic conditions)