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Form Approved
OMB No. #####
Exp. Date: MM/DD/YYYY

Welcome to the Health and Stability Survey!

Thank you for agreeing to participate in our new AmeriSpeak survey! To thank you for sharing your opinions, we will give you a reward of 10 AmeriPoints after completing the survey. If you complete all of the Health and Stability Surveys including this survey, each monthly survey, and the final survey you will earn a bonus of 10 AmeriPoints. As always, your answers are confidential.

This survey will take about 20 to 30 minutes to complete. Please use the "Continue" and "Previous" buttons to

Start Survey

If you have any questions about the survey, you can call the NORC IRB Administrator toll-free at: 866-309-0542.

BURDEN STATEMENT

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Thank you for agreeing to participate in our new AmeriSpeak survey! To thank you for sharing your opinions, we will give you a reward of AmeriPoints after completing the survey. As always, your answers are confidential.

Please use the "Continue" and "Previous" buttons to navigate between the questions within the questionnaire. Do not use your browser buttons.

[PREVIOUS](#) [CONTINUE](#)



For purposes of this survey, you will be asked a series of questions about your health with a particular focus on falls. A fall is being defined as an event that resulted in a person unintentionally coming to rest on the ground, floor, or other lower level. Please keep this definition in mind as you complete the survey.

[PREVIOUS](#) [CONTINUE](#)



Some of the terms in this survey may not be familiar to everyone. For these terms, we have included a blue ⓘ icon next to the word that provides additional information for you. You can hover your mouse on the blue ⓘ icon here to see an example.

[PREVIOUS](#) [CONTINUE](#)



Please remember these three words, you will be asked to recall them later: dog, apple, house

[PREVIOUS](#) [CONTINUE](#)



Are you deaf or do you have serious difficulty hearing?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Do you have serious difficulty walking or climbing stairs?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Do you have difficulty dressing or bathing?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Do you ever need help with planning trips for errands?

- Never
- Rarely
- Sometimes
- Frequently
- Always

[PREVIOUS](#) [CONTINUE](#)



Do you ever need help remembering to take medications?

- Never
- Rarely
- Sometimes
- Frequently
- Always
- Not applicable, no medications taken regularly

[PREVIOUS](#) [CONTINUE](#)



For each of the following statements, please select a yes or no answer.

	Yes	No
I have fallen in the past year.	<input type="radio"/>	<input type="radio"/>
I use or have been advised to use a cane or walker to get around safely.	<input type="radio"/>	<input type="radio"/>
Sometimes I feel unsteady when I am walking.	<input type="radio"/>	<input type="radio"/>
I steady myself by holding onto furniture when walking at home.	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



For each of the following statements, please select a yes or no answer.

	Yes	No
I am worried about falling.	<input type="radio"/>	<input type="radio"/>
I need to push with my hands to stand up from a chair.	<input type="radio"/>	<input type="radio"/>
I have some trouble stepping onto a curb.	<input type="radio"/>	<input type="radio"/>
I often have to rush to the toilet.	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



For each of the following statements, please select a yes or no answer.

	Yes	No
I have lost some feeling in my feet.	<input type="radio"/>	<input type="radio"/>
I take medicines that sometimes make me feel light-headed or more tired than usual.	<input type="radio"/>	<input type="radio"/>
I take medicine to help me sleep or improve my mood.	<input type="radio"/>	<input type="radio"/>
I often feel sad or depressed.	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



Please share the three words shared earlier.

Word 1	<input type="text"/>
--------	----------------------

Word 2	<input type="text"/>
--------	----------------------

Word 3	<input type="text"/>
--------	----------------------

[PREVIOUS](#) [CONTINUE](#)



Do you experience any difficulties with walking?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Do you experience any difficulties with balance?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



We would like to ask some questions about how concerned you are about the possibility of falling. Please reply thinking about how you usually do the activity. If you currently do not do the activity, please answer to show whether you think you would be concerned about falling if you did the activity.

For each of the following activities, please choose the response which is closest to your own opinion to show how concerned you are that you might fall if you did this activity.

	Not at all concerned	Somewhat concerned	Fairly concerned	Very concerned
Getting dressed or undressed	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Taking a bath or shower	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in or out of a chair	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Going up or down stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



We would like to ask some questions about how concerned you are about the possibility of falling. Please reply thinking about how you usually do the activity. If you currently do not do the activity, please answer to show whether you think you would be concerned about falling if you did the activity.

For each of the following activities, please choose the response which is closest to your own opinion to show how concerned you are that you might fall if you did this activity.

	Not at all concerned	Somewhat concerned	Fairly concerned	Very concerned
Reaching for something above your head or on the ground	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking up or down a slope	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Going out to a social event (e.g. religious service, family gathering or club meeting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



How many falls have you had in the past 12 months?

- No falls
- One fall
- Two falls
- Three or more falls

[PREVIOUS](#) [CONTINUE](#)



You indicated you had 3 or more falls in the past 12 months. How many falls have you had in total?

[PREVIOUS](#) [CONTINUE](#)



Were you hurt or injured in any of the falls in the past 12 months?

- No
- Minor injury, did not require medical attention
- Minor injury, did require medical attention
- Severe injury (fracture, etc.)

[PREVIOUS](#) [CONTINUE](#)



What is the year, month, and day of your most recent fall in the past 12 months?

[PREVIOUS](#) [CONTINUE](#)



Let's discuss the circumstances of your most recent fall in the past 12 months.

[PREVIOUS](#) [CONTINUE](#)



What was the time of your most recent fall in the past 12 months? ⓘ

HOURS	MINUTES	AM/PM
Select an answer... ▼	Select an answer... ▼	Select an answer... ▼

PREVIOUS CONTINUE



What was the location of your fall (for example: in the bathroom)?

Inside of home, please specify:

Outside of home, please specify:

In community, please specify:

[PREVIOUS](#) [CONTINUE](#)



What was the direction of your fall?

Please select all that apply

- Left
- Right
- Forward
- Backward
- Can't remember

[PREVIOUS](#) [CONTINUE](#)



What was the cause of your most recent fall in the past 12 months?

Please select all that apply

- Trip
- Slip
- Loss of balance
- Knees gave way
- Fainted
- Feeling dizzy
- Feeling giddy
- Alcohol
- Medications
- Fell out of bed
- Pets
- Stairs
- Other – please specify:

- Unknown

[PREVIOUS](#) [CONTINUE](#)



Are you able to do the following activities without help?

	Yes	No
Bathing or showering	<input type="radio"/>	<input type="radio"/>
Dressing	<input type="radio"/>	<input type="radio"/>
Eating	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



Are you able to do the following activities without help?

	Yes	No
Getting in or out of bed or chairs	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>
Using the toilet	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



Has your need for assistance with bathing or showering, dressing, eating, getting in or out of bed or chairs, walking, or using the toilet, changed since your most recent fall?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Are you able to do the following activities without help?

	Yes	No
Use the telephone	<input type="radio"/>	<input type="radio"/>
Go shopping	<input type="radio"/>	<input type="radio"/>
Prepare meals	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



Are you able to do the following activities without help?

	Yes	No
Light housework	<input type="radio"/>	<input type="radio"/>
Heavy housework	<input type="radio"/>	<input type="radio"/>
Manage money	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



Has your need for assistance with using the telephone, going shopping, preparing meals, housework, or managing money changed since your most recent fall?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Every day
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feeling down, depressed or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Questions about this study? Need help? Check out the FAQ [here](#)

PREVIOUS CONTINUE



Please answer Yes or No to the following:

	Yes	No
Do you take either prescription or over-the-counter medicine to help you sleep?	<input type="radio"/>	<input type="radio"/>
Do you take over the counter medicine to help with pain?	<input type="radio"/>	<input type="radio"/>
Do you take prescription medicine to help with pain?	<input type="radio"/>	<input type="radio"/>
Do you take prescription medicine to help your mood or for sadness?	<input type="radio"/>	<input type="radio"/>
Do you take prescription medicine to help with anxiety or nervousness?	<input type="radio"/>	<input type="radio"/>
Do you take prescription medicine to help with seizures?	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



How many prescription medications are you currently taking?

[PREVIOUS](#) [CONTINUE](#)



Do you have any of the following chronic conditions?

	Yes	No
Arthritis	<input type="radio"/>	<input type="radio"/>
A respiratory condition	<input type="radio"/>	<input type="radio"/>
Parkinson's disease	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



Do you have any of the following chronic conditions?

	Yes	No
Dementia	<input type="radio"/>	<input type="radio"/>
Peripheral neuropathy ⓘ	<input type="radio"/>	<input type="radio"/>
A cardiac condition ⓘ	<input type="radio"/>	<input type="radio"/>
A chronic condition resulting from stroke	<input type="radio"/>	<input type="radio"/>

PREVIOUS CONTINUE



Do you have any of the following chronic conditions?

	Yes	No
Other neurological conditions ⓘ	<input type="radio"/>	<input type="radio"/>
Lower limb amputation ⓘ	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>
Vestibular disorder ⓘ	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



Do you have any of the following chronic conditions?

	Yes	No
Other dizziness	<input type="radio"/>	<input type="radio"/>
Chronic musculoskeletal pain (e.g., back pain)	<input type="radio"/>	<input type="radio"/>
Lower limb joint replacement	<input type="radio"/>	<input type="radio"/>
Other – please specify:	<input type="radio"/>	<input type="radio"/>

[PREVIOUS](#) [CONTINUE](#)



Do you have an uncorrected problem with your vision?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Do you have an uncorrected problem with your ability to feel pressure, pain, or warmth?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Do you have foot problems, such as corns, bunions, or swelling?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Do you often have to go to the bathroom 3 or more times at night?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



In the past three months are you eating less?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



Have you had weight loss in the last 3 to 12 months?

- None
- Minimal (< 2.2 pounds)
- Moderate (2.2-6.6 pounds)
- Marked (> 6.6 pounds)

[PREVIOUS](#) [CONTINUE](#)



During the last 12 months, how often did you usually have any kind of drink containing alcohol?

One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.

- Every day
- 2 to 3 times a week
- Once a week
- 2 to 3 times a month
- Once a month
- 3 or 4 times in the past year
- I did not drink any alcohol in the past year, but I did drink in the past
- I never drank any alcohol in my life

[PREVIOUS](#) [CONTINUE](#)



During the past 12 months, on the days when you drank, about how many drinks did you drink on average?

One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots would count as 2 drinks.

- 1 to 3
- 4 to 7
- 8 to 11
- 12 to 15
- 16 or more

[PREVIOUS](#) [CONTINUE](#)



Would you say that in general your health is...

- Excellent
- Very Good
- Good
- Fair
- Poor

[PREVIOUS](#) [CONTINUE](#)



Have you taken any classes offered by your doctor or community center that focus on physical activity or falls prevention?

- Yes
- No

[PREVIOUS](#) [CONTINUE](#)



What was the name of the class?

[PREVIOUS](#) [CONTINUE](#)



When did you take the class?

- In the last month
- In the last year
- More than one year ago

[PREVIOUS](#) [CONTINUE](#)



Where was the class held?

- In my doctor's office
- A senior center
- A religious center
- Other community center
- Other – please specify:

[PREVIOUS](#) [CONTINUE](#)



We will be following up with you monthly to ask you a similar but shorter series of questions about your health with a particular focus on falls over the next year. In the event we are unable to reach you, we would like to speak with someone who can answer on your behalf or with a proxy. Please list the names and contact information of two individuals, either of which you are comfortable with acting as your proxy.

Proxy nomination #1

Name

Address 1

City

State

City

State

Zip

Phone

Please enter phone number without dashes, for example, 5551213366

Email

PREVIOUS

CONTINUE



We will be sending you a Health and Stability Survey calendar and log to help you keep track of any falls you experience and to help you respond to the upcoming monthly surveys. If for any reason you do not receive the calendar and log, you can email us at support@AmeriSpeak.org or call us toll-free at 888-326-9424.

[PREVIOUS](#) [CONTINUE](#)



Thank you for your time today. To help us improve the experience of AmeriSpeak members like yourself, please give us feedback on this survey.

If you do not have any feedback for us today, please click "Continue" through to the end of the survey so we can make sure your opinions are counted and for you to receive your AmeriPoints reward.

Please rate this survey overall from 1 to 7 where 1 is Poor and 7 is Excellent.

- 1 - Poor
- 2
- 3
- 4
- 5
- 6
- 7 - Excellent

Did you experience any technical issues in completing this survey?

- Yes - please tell us more in the next question
- No

Do you have any general comments or feedback on this survey you would like to share? If you would like a response from us, please email support@AmeriSpeak.org or call (888) 326-9424.



Those are all the questions we have. You have earned a reward of AmeriPoints for completing the survey. If you have any questions at all for us, you can email us at support@amerispeak.org or call us toll-free at (888) 326-9424. Thank you for participating in our new AmeriSpeak survey!

You can close your browser window now if you wish or click Submit below to be redirected to the AmeriSpeak member website.

[PREVIOUS](#) [Submit](#)