[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)

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

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 Asian
   O White
   O Black or African American
   O Native Hawaiian or other Pacific Islander

7. 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

8. 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.**

Arthritis or other bone/joint disease	□□Yes□□□No	High blood pressure/hypertension	□Yes□□□No
Breathing/lung disease	□ Yes□□□ No	Glaucoma/other chronic eye problem	□Yes □□No
Cancer	□ Yes□□□ No	Osteoporosis	□Yes□□□No
Depression	□ Yes□□□ No	Parkinson's Disease	□Yes□□□No
Diabetes	□ Yes□□□ No	Other Chronic Condition(s) (specify):	_____ _____ _____
Heart disease or blood circulation problem	□Yes□□□ No		

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.

10. 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.

11. 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. where did the fall(s) occur (*Please check all that apply)**?***

○ Indoors ○ Outdoors ○ Both indoors and outdoors

c. what happened after you fell and had an injury? *(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 _____

12. How fearful are you of falling?

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

13. 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	O	O	O	O
b. I can find a way to reduce falls	O	O	O	O
c. I can protect myself if I fall	O	O	O	O
d. I can increase my physical strength	O	O	O	O
e. I can become more steady on my feet	O	O	O	O

14. 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

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

16. 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