[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 your last name, last two numbers of your birth year)

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

If you fell since the program began:

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

3. How fearful are you of falling?

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

4. 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	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

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

Participant Post Program Survey (continued)

5. 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

6. 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 feel more satisfied with my life	O	O	O	O
e. I would recommend this program to a friend or relative	O	O	O	O

7. 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

8. 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

9. 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