[Program Name] Participant Information Form

Admin Use Only: ***Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.
State abbreviation: __ __ (e.g., NY, VA, etc.)
First four letters of the site name: __ __ __ __
Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)
Participant number: __ __ (e.g., 01, 02, 03, etc.)

1. Did your health care provider suggest that you attend this program? ☐ Yes ☐ No

2. How old are you today? _____ years

3. Do you live alone? ☐ Yes ☐ No

4. Are you a Caregiver of an older adult? ☐ Yes ☐ No

5. Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

6. What is your race? **Check all that apply.**

	American Indian or Alaska Native		Native Hawaiian or other Pacific Islander
	Asian		White
	Black or African American		Other (please specify)

7. What is the highest grade or level of school that you have completed?

	Some elementary, middle, or high school		Some college or technical school
	High school graduate or GED		College (4 years or more)

8. Has a health care provider ever told you that you have any of the following chronic or progressive conditions (i.e., one that has lasted for three months or more)?

	YES	NO		YES	NO
Alzheimer's Disease or other dementia			Mental health condition		
Anemia			Obesity		
Arthritis/Rheumatic Disease			Osteoporosis (Low Bone Density)		
Asthma/Emphysema/Other Chronic Breathing or Lung			Parkinson's Disease		
Cancer or Cancer Survivor			Stroke		
Chronic Pain			Sudden Weight Loss		
Diabetes (High Blood Sugar)			Traumatic Brain Injury		
Hearing Loss			Urinary Incontinence		
Heart Disease			Vision Impairment		
High Cholesterol			Other Chronic or Progressive Conditions		
Hypertension (High Blood Pressure)					

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

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

10. How often do you feel lonely?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

11. How often do you feel isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

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.

12. In the past 3 months, how many times have you fallen? ____times ☐ None

If you fell in the past three months:

a. how many of these falls caused an injury? *(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. what happened after you fell? *(Please check all that apply)*

☐ Told a family member or friend ☐ Visited my Health Care Provider
☐ Went to an Urgent Care Center ☐ Went to the Emergency Room
☐ Was admitted to the hospital ☐ Did not seek medical care

13. In the past 3 months, has your concern about falling interfered with your normal social activities with family, friends, and neighbors (e.g., avoiding situations with stairs or uneven ground)?

☐ Not at all ☐ A little ☐ Somewhat ☐ A lot

14. How confident are you today that you can do the following activities **without falling**?

Activity	**Very Confident 1**	**Confident 2**	**Somewhat Confident 3**	**Fairly Confident 4**	**Not at all Confident 5**
					
Take a bath or shower					
Reach into cabinets or closets					
Walk around the house					
Prepare meals					
Get in and out of bed					
Answer the door or telephone					
Get in and out of a chair					
Getting dressed and undressed					
Personal grooming (i.e., washing your face)					
Getting on and off the toilet					
Total Score					

15. What best describes your physical activity level?

- ☐ Vigorous-intensity activity at least 3 times per week (jogging, shoveling snow, fitness class)
- ☐ Moderate-intensity activity at least 3 times per week (brisk walking, raking the yard)
- ☐ Light-intensity activity (slow walk, cooking, light household chores)
- ☐ Seldom active (preferring sedentary activity, such as watching TV)

16. What is your current gender (select one)?

- ☐ Man
- ☐ Woman
- ☐ Non-binary
- ☐ Other (please specify) _____
- ☐ Prefer not to answer

17. Do you consider yourself to be transgender?

☐ Yes ☐ No ☐ Prefer not to answer

18. Which of the following best represents how you think of yourself? [Select ONE]

- ☐ Lesbian or gay
- ☐ Straight, that is, not gay or lesbian
- ☐ Bisexual
- ☐ [If respondent is AIAN:] Two-Spirit
- ☐ I use a different term (please specify) _____
- ☐ Don't know
- ☐ Prefer not to answer