

# [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.**

<input type="checkbox"/>	American Indian or Alaska Native
<input type="checkbox"/>	Asian
<input type="checkbox"/>	Black or African American

<input type="checkbox"/>	Native Hawaiian or other Pacific Islander
<input type="checkbox"/>	White
<input type="checkbox"/>	Other (please specify)

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

<input type="checkbox"/>	Some elementary, middle, or high school
<input type="checkbox"/>	High school graduate or GED

<input type="checkbox"/>	Some college or technical school
<input type="checkbox"/>	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*)

- |   |  |
|---|--|
| <input type="checkbox"/> Told a family member or friend | <input type="checkbox"/> Visited my Health Care Provider |
| <input type="checkbox"/> Went to an Urgent Care Center  | <input type="checkbox"/> Went to the Emergency Room      |
| <input type="checkbox"/> Was admitted to the hospital   | <input type="checkbox"/> 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					
<b>Total Score</b>					

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

Paperwork Reduction Act Public Burden Statement: According to the Paperwork Reduction Act of 1995 5 CFR § 1320.8(b)(3), no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-0039). Public reporting burden for this collection of information is estimated to average 0.10 hours per response, including time for gathering, maintaining the data needed, completing, and reviewing the collection of information. The obligation to respond to this collection is required to retain benefits under the statutory authority of the Older Americans Act and Patient Protection and Affordable Care Act. The Administration for Community Living (ACL) will use the set of data collection tools to monitor grantees receiving Evidence-Based Falls Prevention Program cooperative agreements. Data will be kept private to the extent allowed by law. There are no assurances of confidentiality. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Administration for Community Living, U.S. Department of Health and Human Services, 330 C Street, SW, Washington, DC 20201-0008, Attention: Office of Nutrition and Health Promotion Programs (ONHPP), and reference the OMB Control Number 0985-0039. Note: Please do not return the completed Evidence-Based Falls Prevention Program cooperative agreements to this address.