

[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): ____ __ __ __ __ __

1. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?
 Yes No

2. How old are you today? _____years

3. Do you live alone? Yes No

4. Are you: Male or Female?

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

7. What is the highest grade or level of school that you have completed?
 Less than high school
 Some high school
 High school graduate or GED
 Some college or vocational school
 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)? (**Please check all that apply.**)

| | |
|--|---|
| <input type="checkbox"/> Arthritis or other bone/joint disease | <input type="checkbox"/> Heart disease or blood circulation problem |
| <input type="checkbox"/> Breathing/lung disease | <input type="checkbox"/> Glaucoma/ other chronic eye problem |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Other chronic condition: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> None (No chronic conditions) |

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

Participant Information Form (continued)

9. Are you limited in any way in any activities because of physical, mental, or emotional problems?

Yes No

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? none ___times

a. If you fell in the past 3 months, 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

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 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| b. I can find a way to reduce falls | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| c. I can protect myself if I fall | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| d. I can increase my physical strength | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| e. I can become more steady on my feet | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

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

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