Participant Information Form

OMB Control No. 0985-0039
Exp. Date 04/30/2024

Program Name:

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 doctor or other 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: ☐ Male ☐ Female ☐ Prefer not to say

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	

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 conditions (i.e., one that has lasted for three months or more)?

	YES	NO		YES	NO
Alzheimer's Disease or other dementia	☐	☐	Hypertension (High Blood Pressure)	☐	☐
Anxiety Disorder	☐	☐	Kidney Disease	☐	☐
Arthritis/Rheumatic Disease	☐	☐	Obesity	☐	☐
Asthma/Emphysema/Other Chronic Breathing or Lung Problem	☐	☐	Osteoporosis (Low Bone Density)	☐	☐
Cancer or Cancer Survivor	☐	☐	Parkinson's Disease	☐	☐
Chronic Pain	☐	☐	Schizophrenia or Other Psychotic Disorder	☐	☐
Depression	☐	☐	Stroke	☐	☐
Diabetes (High Blood Sugar)	☐	☐	Traumatic Brain Injury	☐	☐
Heart Disease	☐	☐	Urinary Incontinence	☐	☐
High Cholesterol	☐	☐	Other Chronic Condition	☐	☐

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Participant Information Form (continued)

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

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

10. How often do you feel lonely or 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.

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

If you fell in the past three 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. Did you tell anyone, such as a family member, friend, or healthcare provider about this fall, whether or not it resulted in an injury?

☐ Yes ☐ No

c. what happened after you fell? *(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. 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?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

14. Please use an **X** to tell us how sure you are that you can do the following activities.

	Not at all sure	**Somewhat sure**	**Neutral**	**Sure**	**Very Sure**
a. I can find a way to get up if I fall					
b. I can find a way to reduce falls					
c. I can increase my flexibility					
d. I can increase my physical strength					
e. I can become more steady on my feet					

15. What best describes your activity level?

☐ Vigorously active for at least 30 min, 3 times per week
☐ Moderately active at least 3 times per week
☐ Seldom active, preferring sedentary activities