Participant Post Program Survey

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. In general, would you say that your health is:
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. 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.

3. Since this program began, how many times have you fallen? ☐ None ____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. 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

4. How fearful are you of falling?
   ☐ Not at all ☐ A little ☐ Somewhat ☐ A lot

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

Participant Post Program Survey (continued)

6. 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					

7. 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

8. Please use an **X** to tell us your thoughts about this program.

As a result of this program:	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling.					
b. I feel more comfortable talking to my family and friends about falling.					
c. I feel more comfortable increasing my activity.					
d. I feel more satisfied with my life.					
e. I would recommend this program to a friend or relative.					
f. I have reduced my fear of falling.					
g. I plan to continue to exercise.					
h. I have made safety modifications in my home, such as installing grab bars or securing loose rugs.					

9. Since this program began, what have you done to reduce your chance of a fall? **Check all that apply**
   - ☐ Talked to a family member or friend about how I can reduce my risk of falling
   - ☐ Talked to a health care provider about how I can reduce my risk of falling
   - ☐ Had my vision checked
   - ☐ Had my medications reviewed by a health care provider or pharmacist
   - ☐ Participated in or plan to participate in another fall prevention program in my community