[Program Name] Participant Post Program Survey

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.)

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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?
   O Never O Rarely O Sometimes O Often O 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? O none O _____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? O Yes O 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. Please mark the circle that tells us how sure you are that you can do the following activities.

How sure are you that:

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

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

6. 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

7. Please tell us your thoughts about this program. **Check one circle for each question**.

As a result of this program:	**Strongly Disagre**	**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	O	O	O	O	O
b. I feel more comfortable talking to my family and friends about falling	O	O	O	O	O
c. I feel more comfortable increasing my activity	O	O	O	O	O
d. I feel more satisfied with my life	O	O	O	O	O
e. I would recommend this program to a friend or relative	O	O	O	O	O
f. I have reduced my fear of falling	O	O	O	O	O
g. I plan to continue to exercise	O	O	O	O	O
h. I have made safety modifications in my home, such as installing grab bars or securing loose rugs.	O	O	O	O	O

8. Since this program began, what have you done to reduce your chance of a fall?
Check all that apply.

O Talked to a family member or friend about how I can reduce my risk of falling

O Talked to a health care provider about how I can reduce my risk of falling

O Had my vision checked

O Had my medications reviewed by a health care provider or pharmacist

O Participated in or plan to participate in another fall prevention program in my community

9. What best describes your activity level?

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