## [Program Name] Participant Information Form

Admin Use Only: Participant I.D.: The facilitator or program staff should complete this pumber of the participant to the name on the attendance form.  State abbreviation: (e.g., NY, VA, etc.)  Sirst four letters of the site name:  Start date of program: / (e.g., 12/01/19)  Participant number: (e.g., 01, 02, 03, etc.)	part of the form ar	nd mark the sequential
Did your doctor or other health care provider suggest that you attend the Yes       No	his program?	
2. How old are you today?years		
3. Do you live alone?		
4. Are you:		
5. Are you of Hispanic, Latino, or Spanish origin?	No	
6. What is your race? Check all that apply.		
<ul> <li>☐ American Indian or Alaska Native</li> <li>☐ Asian</li> <li>☐ Black or African American</li> <li>☐ Native Hawaiian or other Pacific Islander</li> <li>☐ White</li> </ul>		
7. What is the highest grade or level of school that you have complete	eted?	
☐ Some elementary, middle, or high school ☐ High school graduate or GED ☐ Some college or technical school ☐ College (4 years or more)		
8. Has a health care provider ever told you that you have any of the fol that has lasted for three months or more)?	llowing chroni	c conditions (i.e., one
Alzheimer's Disease or other dementia Anxiety Disorder Arthritis/Rheumatic Disease Asthma/Emphysema/Other Chronic Breathing or Lung Problem Cancer or Cancer Survivor	<ul> <li>☐ Yes</li> <li>☐ Yes</li> <li>☐ Yes</li> <li>☐ Yes</li> <li>☐ Yes</li> <li>☐ Yes</li> </ul>	<ul> <li>□ No</li> <li>□ No</li> <li>□ No</li> <li>□ No</li> <li>□ No</li> </ul>
Chronic Pain	☐ Yes	∐ No

D	epression	☐ Yes	□ No			
D	viabetes (High Blood Sugar)	☐ Yes	□ No			
Н	leart Disease	☐ Yes	□ No			
Н	ligh Cholesterol	☐ Yes	□ No			
Н	(lypertension (High Blood Pressure)	☐ Yes	□ No			
K	idney Disease	☐ Yes	□ No			
C	besity	☐ Yes	□ No			
C	Osteoporosis (Low Bone Density)	☐ Yes	□ No			
P	arkinson's Disease	Yes	□ No			
S	chizophrenia or Other Psychotic Disorder	Yes	☐ No			
S	troke	☐ Yes	∐ No			
T	raumatic Brain Injury	∐ Yes	∐ No			
U	Trinary Incontinence	∐ Yes	∐ No			
O	Other Chronic Condition	☐ Yes	∐ No			
9. Ir	n general, would you say that your health is:					
	☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐	Poor				
10. H	low often do you feel lonely or isolated from those around y	ou?				
	□ Never □ Rarely □ Sometimes □ Often □	Always				
	ext few questions ask about falls. By a fall, we mean when a pe the ground or another lower level.	erson unintent	ionally comes to			
11. Ir	n the past 3 months, how many times have you fallen?	onetime	es			
If	f 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 whether or not it resulted in an injury?	healthcare pro	ovider about this fall,			
	☐ Yes ☐ No					
	c. what happened after you fell? (Please check all that apply	·)				
	☐ Went to the Emergency Room ☐ Was admi	tted to the hos	pital			
		ek medical car	-			
12 H						
14. 11	low fearful are you of falling?					

13. During the <b>last 4 weeks</b> , to what extent has your concern about falling interfered with your normal									
social activities with family, friends, neighbors or groups?									
$\square$ Not at all $\square$ Slightly $\square$	Moderately [	☐ Quite a bit	☐ Extre	nely					
14. Please use an $\mathbf{X}$ 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									
solution utility, proteining seater									

According to the Paperwork Reduction Act of 1995, 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 6 minutes per response, including time for gathering and maintaining the data needed and completing and reviewing the collection of information. The obligation to respond to this collection is required to retain or maintain benefits under the statutory authority of the Older Americans Act and Patient Protection and Affordable Care Act. OMB Control No. 0985-0039 Exp. Date 04/30/2024