

# [Program Name] Participant Information Form

Today's date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
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Participant I.D. (first two letters of your first name, first two letters of your last name, last two numbers of your birth year): \_\_\_\_ \_\_ \_\_ \_\_ \_\_ \_\_

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1. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?

Yes  No

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

Excellent  Very good  Good  Fair  Poor

3. How old are you today? \_\_\_\_\_years

4. Do you live alone?  Yes  No

5. Are you:  Male or  Female ?

6. Are you of Hispanic, Latino, or Spanish origin?  Yes  No

7. 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

8. 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

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

Yes  No

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

## Participant Information Form (continued)

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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.

10. 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

11. How fearful are you of falling?

- Not at all       A little       Somewhat       A lot

12. 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"/>

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?

- Extremely       Quite a bit       Moderately       Slightly       Not at all

14. 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)               |