[Program Name] Participant Information Form

Today's date: __ __/ __ __/__ __ __ __
M M D D Y Y Y Y

Participant I.D. (first two initials of your first name, first two initials of your last name, last two numbers of your birth year): __ __ __ __ __ __

---

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

   O Yes O 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? O Yes O No

5. Are you: O Male or O Female ?

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

7. What is your race? Check all that apply.
   O American Indian or Alaska Native
   O Asian
   O Black or African American
   O Native Hawaiian or other Pacific Islander
   O White

8. What is the highest grade or level of school that you have completed?
   O Less than high school
   O Some high school
   O High school graduate or GED
   O Some college or vocational school
   O College graduate or higher

9. Do you have a disability (i.e., a physical, developmental and/or mental impairment) that greatly limits one or more of your major life activities (such as caring for yourself, talking, being mobile, working, or being independent)?

   O Yes O No

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

Participant Information Form (continued)

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? O none O ________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	○	○	○	○
b. I can find a way to reduce falls	○	○	○	○
c. I can protect myself if I fall	○	○	○	○
d. I can increase my physical strength	○	○	○	○
e. I can become more steady on my feet	○	○	○	○

13. During the <u>last 4 weeks</u>, 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? (Please mark all that apply.)

- ☐ Arthritis/rheumatic disease
- ☐ Breathing/lung disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart disease or blood circulation problem
- ☐ Glaucoma/ other chronic vision problem
- ☐ Other chronic condition: ____________________
- ☐ None (No chronic conditions)