[Program Name] Participant Information Form

Today’s date:  __ __/ __ __/__ __ __ __

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:
   O Excellent   O Very good   O Good   O Fair   O 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.
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?
   O Not at all  O A little  O Somewhat  O 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:
   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

   Very sure  Sure  Somewhat sure  Not at all sure

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?
   O Extremely  O Quite a bit  O Moderately  O Slightly  O 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  □ Heart disease or blood circulation problem
   □ Breathing/lung disease  □ Glaucoma/ other chronic vision problem
   □ Depression  □ Other chronic condition: ________________________
   □ Diabetes  □ None (No chronic conditions)