OMB Control No. 0985-0039

Exp. Date 03/31/2021

Program Name:

First Session Survey

By filling out this form, I agree that the information collected on program forms may be studied and shared, with no way to link it back to me.

Today's Date:

Participant ID: __ __ / __ __ / __ __ (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. How old are you today? ___________ years
3. Do you live alone? ◯ Yes ◯ No
4. Are you: ◯ Male or ◯ Female?
5. Are you of Hispanic, Latino, or Spanish origin? ◯ Yes ◯ No
6. 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
7. 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
8. Are you limited in any way in any activities because of physical, mental, or emotional problems? ◯ Yes ◯ No
9. In general, would you say that your health is:
   ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor
10. How fearful are you of falling?
   ◯ Not at all ◯ A little ◯ Somewhat ◯ A lot

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

11. 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)? **Check Yes or No.**

Arthritis or other bone/joint disease	OYes ONo	High blood pressure/hypertension	OYes ONo
Breathing/lung disease	OYes ONo	Glaucoma/other chronic eye problem	OYes ONo
Cancer	OYes ONo	Osteoporosis	OYes ONo
Depression	OYes ONo	Parkinson's Disease	OYes ONo
Diabetes	OYes ONo	Other Chronic Condition(s) (specify):	
Heart disease/blood circulation problem	OYes ONo		

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.

12. In the past 3 months, how many times have you fallen? ◯ none ◯ ______ times

If you fell in the past 3 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. where did the fall(s) occur? (Please check all that apply)

◯ Indoors ◯Outdoors ◯Both indoors and outdoors

c. what happened after you fell and had an injury? (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

13. 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	O	O	O	O
b) I can find a way to reduce falls	O	O	O	O
c) I can protect myself if I fall	O	O	O	O
d) I can increase my physical strength	O	O	O	O
e) I can become more steady on my feet	O	O	O	O

14. 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

15. I have made safety modifications in my home, such as installing grab bars or securing loose rugs, to reduce my risk of falling _____ True _____ False

16. 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

Thank you for completing the Falls Prevention First Session Survey