Stepping On Participant Information Form

Today's date: ____/____/ _____ Name_____
M M D D Y Y Y Y

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

1. How did you hear about this program? (You may select more than one response)

   - □ Friend or family member
   - □ Health care provider or hospital
   - □ Recreation Center/YMCA
   - □ Senior Center
   - □ Home Health Agency
   - □ Local Health Department
   - □ Other (please specify):

2. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program? O Yes O No

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

   O Excellent O Very good O Good O Fair O Poor

4. How old are you today? _____ years

5. Do you live alone? O Yes O No

6. Are you: O Male or O Female ?

7. What is your Zipcode?_____ 8. What county do you live in_____
   (Adams, Alamosa, El Paso, etc.)

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

10. 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

11. 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

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

    O Yes O No

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

For Program Use Only:
Program ID: __ - __ - __ __ __ __ - __ __ - __ __ __

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.

13. 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

14. How fearful are you of falling?

    ○ Not at all ○ A little ○ Somewhat ○ A lot

15. 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	○	○	○	○

16. 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

17. 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**.)

    ☐ Arthritis or other bone/joint disease
    ☐ Breathing/lung disease
    ☐ Depression
    ☐ Diabetes
    ☐ Heart disease or blood circulation problem
    ☐ Glaucoma/ other chronic eye problem
    ☐ Other chronic condition: _____
    ☐ None (No chronic conditions)

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