

Stepping On Participant Post Program Survey

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

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

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

- Excellent Very good Good Fair Poor

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.

2. Since this program began, how many times have you fallen? none _____ times

a. If you fell since this program began, 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

3. How fearful are you of falling?

- Not at all A little Somewhat A lot

4. Has this program reduced your fear of falling? Yes No

5. 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"/>

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

For Program Use Only:

Program ID: ____ - ____ - ____ - ____ - ____

