**Admin Use Only: *Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.

State abbreviation: \_\_ \_\_ (e.g., NY, VA, etc.)

First four letters of the site name: \_\_ \_\_ \_\_ \_\_

Start date of program: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_ (e.g., 12/01/19)

Participant number: \_\_ \_\_ (e.g., 01, 02, 03, etc.)

**Matter of Balance Participant Post Program Survey**

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

□ Excellent □ Very Good □ Good □ Fair □ Poor

1. How often do you feel lonely or isolated from those around you?

□ Never □ Rarely □ Sometimes □ Often □ Always

***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.***

1. **Since this program began**, how many times have you fallen? □ None □\_\_\_\_times

***If you fell since the program began:***

1. 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

1. Did you tell anyone, such as a family member, friend, or healthcare provider about this fall,

whether or not it resulted in an injury?

□ Yes □ No

c. what happened after you fell? *(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

1. How fearful are you of falling?

□ Not at all □ A little □ Somewhat □ A lot

1. 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?

□ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

Page 1 of 2

**Participant Post Program Survey** (continued)

1. Please use an **X** to tell us how sure you are that you can do the following activities.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not at all sure** | **Somewhat sure** | **Neutral** | **Sure** | **Very 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 increase my flexibility |  |  |  |  |  |
| d. I can increase my physical strength |  |  |  |  |  |
| e. I can become more steady on my feet |  |  |  |  |  |

1. What best describes your activity level?

□ Vigorously active for at least 30 min, 3 times per week

□ Moderately active at least 3 times per week

□ Seldom active, preferring sedentary activities

1. Please use an **X** to tell us your thoughts about this program.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **As a result of this program:** | **Strongly** **Disagree** | **Disagree** | **Neither agree****nor disagree** | **Agree** | **Strongly Agree** |
| a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling. |  |  |  |  |  |
| b. I feel more comfortable talking to my family and friends about falling. |  |  |  |  |  |
| c. I feel more comfortable increasing my activity. |  |  |  |  |  |
| d. I feel more satisfied with my life. |  |  |  |  |  |
| e. I would recommend this program to a friend or relative. |  |  |  |  |  |
| 1. I have reduced my fear of falling.
 |  |  |  |  |  |
| 1. I plan to continue to exercise.
 |  |  |  |  |  |
| 1. I have made safety modifications in my home, such as installing grab bars or securing loose rugs.
 |  |  |  |  |  |

1. Since this program began, what have you done to reduce your chance of a fall? **Check all that apply**

|  |  |
| --- | --- |
|  | Talked to a family member or friend about how I can reduce my risk of falling |
|  | Talked to a health care provider about how I can reduce my risk of falling |
|  | Had my vision checked |
|  | Had my medications reviewed by a health care provider or pharmacist |
|  | Participated in or plan to participate in another fall prevention program in my community |

Page 2 of 2