**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 Information Form**

1. Did your doctor or other health care provider suggest that you attend this program?
□ Yes □ No
2. How old are you today?    years
3. Do you live alone? □ Yes □ No
4. Are you: □ Male □ Female □ Prefer not to say
5. Are you of Hispanic, Latino, or Spanish origin? □ Yes □ No
6. What is your race? **Check all that apply.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | American Indian or Alaska Native |  |  | Native Hawaiian or other Pacific Islander |
|  | Asian |  |  | White |
|  | Black or African American |  |  |  |

1. What is the highest grade or level of school that you have completed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Some elementary, middle, or high school |  |  | Some college or technical school  |
|  | High school graduate or GED |  |  | College (4 years or more)  |

1. 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)?

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** | **NO****YES** | **YES** | **NO** |
| Alzheimer’s Disease or other dementia |  |  | Hypertension (High Blood Pressure) |  |  |
| Anxiety Disorder |  |  | Kidney Disease |  |  |
| Arthritis/Rheumatic Disease |  |  | Obesity |  |  |
| Asthma/Emphysema/Other Chronic Breathing or Lung Problem |  |  | Osteoporosis (Low Bone Density) |  |  |
| Cancer or Cancer Survivor |  |  | Parkinson’s Disease |  |  |
| Chronic Pain |  |  | Schizophrenia or Other Psychotic Disorder |  |  |
| Depression |  |  | Stroke |  |  |
| Diabetes (High Blood Sugar) |  |  | Traumatic Brain Injury |  |  |
| Heart Disease |  |  | Urinary Incontinence |  |  |
| High Cholesterol |  |  | Other Chronic Condition |  |  |

Page 1 of 2

**Participant Information Form** (continued)

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. **In the past 3 months**, how many times have you fallen? □ None □ \_\_\_\_times

***If you fell in the past three months:***

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

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

16. What is your zip code? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 2 of 2