Participant Entry Form

Please fill out this form so we can learn more about you.
The information on this form will remain confidential.

1. Today's Date: __ __ / __ __ / __ __ __ __
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2. ID: Participant's first two letters first name, MI, First two letters of last name, and last two numbers of your birth year:

____ ____ ____ ____ ____ ____
First1 First2 Last1 Last2 BirthYr3 BirthYr4

3. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?

□ Yes □ No

4. How old are you today? ____________Years

5. Do you live alone? □ Yes □ No

6. What is your gender? □ Male □ Female

7. Are you of Hispanic, Latino, or Spanish origin? □ Yes □ No

8. What is your race? Check all that apply.

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

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

□ Less than high school
□ Some high school
□ High school graduate or GED
□ Some college or vocational school
□ College graduate or higher

Health Insurance Information (optional)

10. What health insurance are you currently covered by for healthcare needs (check all that apply)

□ Medicaid
□ Medicare
□ TriCare
□ Veterans Health
□ Private Insurance Type: ____
□ No Insurance

11. Have you taken this falls prevention program before?

□ Yes □ No

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

□ Excellent □ Very good □ Good □ Fair □ Poor

13. 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)

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

□ Yes □ No

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.

15. How fearful are you of falling?

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

16. In the past 3 months, how many times have you fallen? □ none □ _____# times

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.) **_______# of falls causing an injury**

17. Please check the box 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				

18. 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?

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

Thank you for taking this survey!

This section to be completed by the Evaluator

Evaluator: See STEADI handouts for instructions to perform tests. Record the participant's scores on this page.

Evaluator's Name: ________________________________ Date:_______________

TIMED UP & GO (TUG)

Trial	Seconds
1 (Practice)	
2	
3	
	Average of trials two and three = _____ seconds (TUG score)

Walking Aid used? □ Yes □ No Type of aid: __________________

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30 SECOND SIT TO STAND

______ # of Stands (put "0" if they cannot perform 1 as instructed)