new hampshire falls risk reduction task force

Participant Post Program Survey

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, First two letters of last name, and last two numbers of your birth year:

_____	_____	_____	_____	_____	_____
First1	First2	Last1	Last2	BirthYr3	BirthYr4

2. 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.

3. Since this program began, how many times have you fallen? □ None □ _____# times

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

4. How fearful are you of falling?

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

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

6. 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				

7. 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

8. Please tell us your thoughts about this program. Check one square for each question.

As a result of this program:	Strongly Agree	Agree	Disagree	Strongly Disagree
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 plan to continue exercising.				
e. I feel more satisfied with my life.				
f. I would recommend this program to a friend or relative.				

9. Since this program began, what have you done to reduce your chance of a fall? <u>Check all that apply.</u>

□ 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 another fall prevention program in my community

□ Did exercises I learned in this program at home

□ Made changes in my home to reduce my risk of falling (for example, secured rugs or improved lighting)

Thank you for taking this survey!