



## 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:     /    /      
                    m  m      d  d      y  y  y  y

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 Middle1 Last1 Last2 BirthYr3 BirthYr4

3. How old are you today? \_\_\_\_\_ Years

4. Do you live alone?             Yes     No

5. What is your gender?             Male     Female

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

7. 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

8. 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

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

- Yes     No

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

- Excellent
- Very good
- Good
- Fair
- Poor

**12. 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
- Heart disease or blood circulation problem
- Breathing/lung disease
- Glaucoma/ other chronic eye problem
- Depression
- Other chronic condition: \_\_\_\_\_
- Diabetes
- None (No chronic conditions)
- Parkinson’s Disease

**13. 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.**

**14. How fearful are you of falling?**

- Not at all
- A little
- Somewhat
- A lot

15. 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

16. 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				

17. 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: \_\_\_\_\_

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### **TIMED UP & GO (TUG)**

<b>Trial</b>	<b>Seconds</b>
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)