new hampshire falls risk reduction task force

# 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 | 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

□Breathing/lung disease

□Depression

□Diabetes

□Parkinson's Disease

□Heart disease or blood circulation problem

□Glaucoma/ other chronic eye problem

□Other chronic condition: _____

□None (No chronic conditions)

**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 <u>the last 4 weeks</u>, 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: _____

---

## 30 SECOND SIT TO STAND

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