Matter of Balance Participant Information Form

OMB Control No. 0985-0039
Exp. Date 03/31/2021

Today's date: _____/ _____/_____
M M D D Y Y Y Y

Participant I.D. __ __ __ __ __ __ (first two letters of your first name, first two letters of your last name, last two numbers of your birth year)
Eg. Jane Smith, 1950 would be JASM50

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

   O Yes O No

2. How old are you today? _____ years

3. Do you live alone? O Yes O No

4. Are you: O Male or O Female?

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

6. What is your race? **Check all that apply**.
   - O American Indian or Alaska Native
   - O Asian
   - O White
   - O Black or African American
   - O Native Hawaiian or other Pacific Islander

7. What is the highest grade or level of school that you have completed?
   - O Less than high school
   - O Some high school
   - O High school graduate or GED
   - O Some college or vocational school
   - O College graduate or higher

8. 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)? **Check Yes or No.**

Arthritis or other bone/joint disease	○Yes ○No	High blood pressure/hypertension	○Yes ○No
Breathing/lung disease	○ Yes ○ No	Glaucoma/other chronic eye problem	○Yes ○No
Cancer	○ Yes ○ No	Osteoporosis	○Yes ○No
Depression	○ Yes ○ No	Parkinson's Disease	○Yes ○No
Diabetes	○ Yes ○ No	Other Chronic Condition(s) (specify):	_____ _____ _____
Heart disease or blood circulation problem	○Yes ○ No		

9. Are you limited in any way in any activities because of physical, mental, or emotional problems? O Yes O No

Please turn this paper over and fill out the other side.

10. 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.

11. In the past 3 months, how many times have you fallen? O none O _____times

If you fell in the past 3 months:

a. 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

b. where did the fall(s) occur (*Please check all that apply)**?***

○ Indoors ○ Outdoors ○ Both indoors and outdoors

c. what happened after you fell and had an injury? *(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 _____

12. How fearful are you of falling?

○ Not at all ○ A little ○ Somewhat ○ A lot

13. Please mark the circle 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	O	O	O	O
b. I can find a way to reduce falls	O	O	O	O
c. I can protect myself if I fall	O	O	O	O
d. I can increase my physical strength	O	O	O	O
e. I can become more steady on my feet	O	O	O	O

14. 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

15. I have made safety modifications in my home, such as installing grab bars or securing loose rugs, to reduce my risk of falling. __ True __ False

16. What best describes your activity level?

O Vigorously active for at least 30 min, 3 times per week
O Moderately active at least 3 times per week
O Seldom active, preferring sedentary activities