

# Tai Ji Quan: Moving for Better Balance

## Participant Information Form (WEEK 1)

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?

Yes     No

2. How old are you today?          years

3. Do you live alone?     Yes     No

4. Are you:     Male    or     Female?

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

6. What is your race? **Check all that apply.**

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

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

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

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	<input type="radio"/> Yes <input type="radio"/> No	High blood pressure/hypertension	<input type="radio"/> Yes <input type="radio"/> No
Breathing/lung disease	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma/other chronic eye problem	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's Disease	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Other Chronic Condition(s) (specify):	_____
Heart disease or blood circulation problem	<input type="radio"/> Yes <input type="radio"/> No		_____

9. Are you limited in any way in any activities because of physical, mental, or emotional problems?     Yes     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?  none     \_\_\_\_\_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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I can find a way to reduce falls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I can protect myself if I fall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I can increase my physical strength	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I can become more steady on my feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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?

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

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## This section to be completed by the Evaluator

Evaluator: See full copy of instructions for each measurement. 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)