Last Revised 6/30/24

Fit and Strong! Participant Post-Survey

Participant Number or Name: _____

Workshop ID: _____ **Site Name:** _____

Start date of program: _____ / _____ / _____ (e.g., 05/01/23)

Program Name:
☒ Fit and Strong!

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1. Since this program began, I have applied the skills I learned in this program to: **Check all that apply.**

☐	Manage emotions like stress, depression, anger, fear, or frustration
☐	Manage pain, fatigue, or other symptoms of my chronic condition(s)
☐	Increase my strength, flexibility, endurance, or overall physical fitness
☐	Make a medication list that includes all current medications, dosages, and dates started
☐	Solve a problem or issue I was experiencing in my life
☐	Help someone else use a technique I learned in this program

2. How likely is it that you would recommend this program to a friend or family member?

Not at all likely ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely likely

3. Would you be willing to share your story to help other people gain access to these programs?
☐ Yes ☐ No

4. What was most valuable to you in this program?

_____

_____

_____

5. Please provide any thoughts or feedback about the program leader(s):

_____

_____

_____

IDPH Post-Survey

Hello. Thank you for your participation in the Fit & Strong! program. As a class participant we are asking you to fill out this brief survey that will ask you questions about your general health and exercise habits. We ask you to complete this survey at the start and end of your Fit & Strong! class. This information is used to assess the impact the Fit & Strong! program is having on its participants.

Your name will NOT be attached to your survey, instead an anonymous ID will be used (e.g., Participant 01).

Your participation is voluntary. You may skip any questions you do not wish to answer.

If you have any questions about this survey, please ask your Fit & Strong! class instructor

Thank you!

1) Your Name/Identifier

(Note: Names will not be sent to the Fit & Strong! project team, only anonymous identifiers, like Participant 01).

_____

2) Today's Date

_____

3) Name of Organization Hosting this Class:

_____

4) Name of Instructor(s) Leading this Class:

_____

Please complete the questions below that asks about FALLS. You can skip any questions you do not feel comfortable answering.

In the past 3 months, have you fallen?	◯ No ◯ Yes
How many times?	_____
If you fell in the last 3 months, how many of these falls caused an injury? (By injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor)	_____
How fearful are you of falling?	◯ Not at All ◯ A Little ◯ Somewhat ◯ A Lot
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
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

Please complete the survey below that asks about how often you feel the way desribed below. You can skip any questions that you do not feel comfortable answering.

39) How often do you feel a lack of companionship?
- ◯ Hardly ever/never
- ◯ Some of the time
- ◯ Often

40) How often do you feel left out?
- ◯ Hardly ever/never
- ◯ Some of the time
- ◯ Often

41) How often do you feel isolated from others?
- ◯ Hardly ever/never
- ◯ Some of the time
- ◯ Often

Please complete the survey below that asks about how often you feel the way desribed below. You can skip any questions that you do not feel comfortable answering.

During the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
42)	I feel fatigued	○	○	○	○	○
43)	I have trouble starting things because I am tired	○	○	○	○	○
44)	How run-down did you feel on average?	○	○	○	○	○
45)	How fatigued were you on average?	○	○	○	○	○

In the past 7 days...

		Very poor	Poor	Fair	Good	Very good
46)	My sleep quality was	○	○	○	○	○

In the past 7 days...

		Not at all	A little bit	Somewhat	Quite a bit	Very much
47)	My sleep was refreshing	○	○	○	○	○
48)	I had a problem with my sleep	○	○	○	○	○
49)	I had difficulty falling asleep	○	○	○	○	○

Ability to Participate in Social Roles and Activities

		Never	Rarely	Sometimes	Usually	Always
50)	I have trouble doing all of my regular leisure activities with others	○	○	○	○	○
51)	I have trouble doing all of the family activities that I want to do	○	○	○	○	○
52)	I have trouble doing all of my usual work (include work at home)	○	○	○	○	○
53)	I have trouble doing all of the activities with friends that I want to do	○	○	○	○	○

Please complete the survey below that ask about your use of HEALTHCARE SERVICES. You can skip any questions that you do not feel comfortable answering.

Have you ever had a total joint replacement?	◯ Yes ◯ No
Check all total joint replacement surgeries you've had.	☐ Right Hip ☐ Right Knee ☐ Left Hip ☐ Left Knee ☐ Other
If Other, please specify.	_____
Please list the date of the joint replacement/s (month and year)	_____
Are you considering having joint replacement surgery at this time?	◯ Yes ◯ No
On a scale from 1-10, how strongly do you feel that you will need HIP surgery in the next year? 1 being not strongly and 10 being very strongly.	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10
On a scale from 1-10, how strongly do you feel that you will need KNEE surgery in the next year? 1 being not strongly and 10 being very strongly.	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Please complete the survey below that asks about PAIN, STIFFNESS, AND FUNCTION OF YOUR KNEES AND HIPS. Select one number only for each question.

The following questions concern the amount of PAIN you are currently experiencing in your hips and/or knees. For each situation, please indicate the amount of pain you recently experienced using the following scale: None, Mild, Moderate, Severe, Extreme.

QUESTION: How much PAIN do you have?

		None	Mild	Moderate	Severe	Extreme
61)	Walking on a flat surface	◯	◯	◯	◯	◯
62)	Going up or down stairs	◯	◯	◯	◯	◯
63)	At night while in bed	◯	◯	◯	◯	◯
64)	Sitting or lying	◯	◯	◯	◯	◯
65)	Standing upright	◯	◯	◯	◯	◯

The following questions concern the amount of joint STIFFNESS (not pain) you are currently experiencing in your hips and/or knees. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints. Select one number only for each question.

		None	Mild	Moderate	Severe	Extreme
66)	How severe is your stiffness after first waking in the morning?	◯	◯	◯	◯	◯
67)	How severe is your stiffness after sitting, lying, or resting later in the day?	◯	◯	◯	◯	◯

The following questions concern your PHYSICAL FUNCTION. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you are currently experiencing due to arthritis in your hips and/or knees. Select one number only for each question.

QUESTION: What degree of difficulty do you have with...

		None	Mild	Moderate	Severe	Extreme
68)	Descending (walking DOWN) stairs	◯	◯	◯	◯	◯
69)	Ascending (walking UP) stairs	◯	◯	◯	◯	◯
70)	Rising from sitting	◯	◯	◯	◯	◯
71)	Standing	◯	◯	◯	◯	◯
72)	Bending to the floor	◯	◯	◯	◯	◯
73)	Walking on a flat surface	◯	◯	◯	◯	◯
74)	Getting in/ out of a car	◯	◯	◯	◯	◯
75)						

	Going shopping	○	○	○	○	○
76)	Putting on socks/ stockings	○	○	○	○	○
77)	Rising from bed	○	○	○	○	○
78)	Taking off socks/ stockings	○	○	○	○	○
79)	Lying in bed	○	○	○	○	○
80)	Getting in/ out of the bathtub	○	○	○	○	○
81)	Sitting	○	○	○	○	○
82)	Getting on/ off of the toilet	○	○	○	○	○
83)	Heavy domestic duties	○	○	○	○	○
84)	Light domestic duties	○	○	○	○	○

Please complete the survey below that asks about your current LEVEL OF PHYSICAL ACTIVITY.

Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation.

The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

Examples of Activities:

<table>
<tr>
<td>Light activities
• your heart beats slightly faster than normal
• you can talk and sing</td>
<td> 
Walking Leisurely
 
Stretching
 
Vacuuming or Light Yard Work</td>
</tr>
<tr>
<td>Moderate activities
• your heart beats faster than normal
• you can talk but not sing</td>
<td> 
Fast Walking
 
Aerobics Class
 
Strength Training
 
Swimming Gently</td>
</tr>
<tr>
<td>Vigorous activities
• your heart rate increases a lot
• you can’t talk or your talking is broken up by large breaths</td>
<td> 
Stair Machine
 
Jogging or Running
 
Tennis, Racquetball, Pickleball or Badminton</td>
</tr>
</table>

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89) I rarely or never do physical activity.

◯ Yes
◯ No

90)	I do some LIGHT or MODERATE physical activities, but not every week.	◯ Yes ◯ No
91)	I do some LIGHT physical activity every week.	◯ Yes ◯ No
92)	I do MODERATE physical activity every week, but less than 30 minutes a day or 5 days a week.	◯ Yes ◯ No
93)	I do VIGOROUS physical activity every week, but less than 20 minutes, 3 or more days per week.	◯ Yes ◯ No
94)	I do 30 minutes or more per day of MODERATE physical activities, 5 or more days a week	◯ Yes ◯ No
95)	I do 20 minutes of more a day of VIGOROUS physical activities, 3 or more days a week	◯ Yes ◯ No
96)	I do activities to increase muscle STRENGTH, such as lifting weights or calisthenics, once a week or more.	◯ Yes ◯ No
97)	I do activities to increase FLEXIBILITY, such as stretching or yoga, once a week or more.	◯ Yes ◯ No
98)	Sometimes I feel unsteady when I am walking.	◯ Yes ◯ No
99)	I steady myself by holding onto furniture when walking at home.	◯ Yes ◯ No

Please complete the survey below.

100) In general, would you say that your health is

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor

101) What is your weight in pounds?

_____

102) On a scale from 1-10, how sure are you that you can manage your condition so that you can do the things you need and want to do with 1 being totally unsure and 10 being totally sure?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
- ◯ 10

103) How often do you feel lonely?

- ◯ Always
- ◯ Often
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

104) How often do you feel isolated from those around you?

- ◯ Always
- ◯ Often
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

105) Since this program began, what have you done to manage your chronic condition(s)? Select all that apply.

- ☐ Talked to a family member or friend about my health
- ☐ Talked to a healthcare provider about how I can better manage my chronic condition
- ☐ Had my medication reviewed by a pharmacist or healthcare provider
- ☐ Started or continued to exercise
- ☐ Made changes to how I choose the food I eat
- ☐ Participate in or plan to participate in another health-related or exercise program in my community

106) How would you rate your overall satisfaction with the quality of the program?

- ◯ Very Dissatisfied
- ◯ Dissatisfied
- ◯ Okay
- ◯ Satisfied
- ◯ Very Satisfied

Attendance Record

Please complete the attendance record for this participant. Check the box for each class session that the participant attended. Leave boxes unchecked if the participant did not attend that session.

Thank you!

Attendance Record. Please check the boxes for each class this participant attended. Leave boxes blank for any classes this participant did not attend.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
107) Classes Attended (Select all that apply)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐