

Falls Prevention Participant Post-Survey

Participant Number or Name: _____

Participant Date of Birth: ___ / ___ / ___ (e.g., 12/01/21)

Workshop ID: ___ (e.g., 01, 02, 03, etc.)

Provider Name: _____ (e.g., XYZ Organization)

Start date of program: ___ / ___ / ___ (e.g., 12/01/21)

Program Name:

- A Matter of Balance Tai Chi for Arthritis and Fall Prevention
 Bingocize

How did you hear about this class?

- Physician or member of my healthcare team Care Coordinator
 Insurance Company Family member/friend
 Community Organization Other: _____

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

- Excellent Very Good Good Fair Poor

2. How often do you feel lonely or isolated from those around you?

- Never Rarely Sometimes Often Always

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.

3. Since this program began, how many times have you fallen? None ___ times

If you fell since the program began:

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. Did you tell anyone, such as a family member, friend, or healthcare provider about this fall, whether or not it resulted in an injury?

- Yes No

c. what happened after you fell? (*Please check all that apply*)

Falls Prevention Participant Post-Survey

- Went to the Emergency Room Was admitted to the hospital
 Visited my Primary Care Physician Did not seek medical care

4. How fearful are you of falling?

- Not at all A little Somewhat A lot

5. 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?

- Not at all Slightly Moderately Quite a bit Extremely

6. Please use an **X** to tell us how sure you are that you can do the following activities.

	Not at all sure	Somewhat sure	Neutral	Sure	Very 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 increase my flexibility					
d. I can increase my physical strength					
e. I can become more steady on my feet					

7. 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

8. Please use an **X** to tell us your thoughts about this program.

As a result of this program:	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling.					
b. I feel more comfortable talking to my family and friends about falling.					
c. I feel more comfortable increasing my activity.					
d. I feel more satisfied with my life.					
e. I would recommend this program to a friend or relative.					
f. I have reduced my fear of falling.					
g. I plan to continue to exercise.					
h. I have made safety modifications in my home, such as installing grab bars or securing loose rugs.					

Falls Prevention Participant Post-Survey

9. Since this program began, what have you done to reduce your chance of a fall? **Check all that apply.**

- Talked to a family member or friend about how I can reduce my risk of falling
- Talked to a health care provider about how I can reduce my risk of falling
- Had my vision checked
- Had my medications reviewed by a health care provider or pharmacist
- Participated in or plan to participate in another fall prevention program in my community

10. The UCLA 3-item Loneliness scale:

	Hardly ever	Some of the time	Often
a. How often do you feel that you lack companionship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How often do you feel left out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How often do you feel isolated from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. The class helped me achieve the goals I set in my action plan(s):

- Yes No

12. Would you be willing to share your story to help other people gain access to these programs?

- Yes No

13. What is most valuable to you in this program?

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

15. Please provide any other information you would like us to know:
