

Fall Prevention: Participant Post Program Survey

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 last name, last two numbers of your birth year): ____ _

1. 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.

2. Since this program began, how many times have you fallen? none _____ times

a. If you fell since this program began, 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

3. How fearful are you of falling?

- Not at all A little Somewhat A lot

4. Has this program reduced your fear of falling? Yes No

5. 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"/>

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

Participant Post Program Survey (continued)

6. 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

7. Please tell us your thoughts about this program. **Check one circle for each question.**

As a result of this program:	Strongly Agree	Agree	Disagree	Strongly Disagree
a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I feel more comfortable talking to my family and friends about falling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I feel more comfortable increasing my activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I plan to continue exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I feel more satisfied with my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. I would recommend this program to a friend or relative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. 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 another fall prevention program in my community
- Did exercises I learned in this program at home
- Made changes in my home to reduce my risk of falling (for example, secured rugs or improved lighting)

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