

# 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)

**PAPERWORK REDUCTION ACT STATEMENT**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0985-0039. The time required to complete this information collection is estimated to average 6 minutes per response. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Administration for Community Living, 1 Massachusetts Avenue, N.W., Room 5203, Washington, D.C. 20001, Attention: PRA Reports Clearance Officer



# Fall Prevention: Participant Post-Program Supplement Form

- The location for this program was a suitable physical environment  
 Strongly agree     Agree     Disagree     Strongly disagree
- How would you rate the sense of community among you and your fellow program participants during the program?  
 Very close     Somewhat close     A little close     Not at all close

3. Please tell us to what extent you agree that the program has been helpful. **Check one circle for each question.**

This program has helped me:	Strongly Agree	Agree	Disagree	Strongly Disagree
a. Prevent falls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Continue to work or perform daily activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Manage stress and fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Set and achieve goals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. Please tell us your thoughts about the program leader. **Check one circle for each question.**

The leader of this program:	Strongly Agree	Agree	Disagree	Strongly Disagree
a. Was easy to understand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Was well organized	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Was respectful to me and others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. After taking this workshop, I am feeling \_\_\_\_\_ about my health.  
 Much better     Better     About the same     Worse

6. After taking this workshop, I am feeling \_\_\_\_\_ about my ability to manage my health and the risk of falling.  
 Much more confident     More confident     About the same     Less confident

7. In general, I would say that my sense of well-being is:

- Excellent       Very good       Good       Fair       Poor

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

---

---

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

---

---