JUNIPER
Your Health. Your Community.

Registration Form

(If not already registered on yourjuniper.org)

First Name*_____Last Name*_____ Phone_____

Email Address_____ Date of Birth*_____

Address*_____City*_____State*____ Zip*_____

Emergency Contact Name and Phone _____

Please list any special accommodations _____

Privacy Policy

To help Juniper track how the program assists people to manage their health issues, and to improve and sustain the program, Juniper may choose to use information you provide to us for these purposes. Information you provide to us may include identifying information and responses to class surveys. Your response to class surveys, other than identifying information, is optional in most cases. By registering for a class, you consent to Juniper's Privacy Policy. Juniper's Privacy Policy, effective December 1, 2017, is to protect and use your information as follows:

- Juniper may aggregate or combine data from class participants and share this combined information with third parties. Your identifying information is removed. Third parties may include healthcare organizations, aging services organizations, private foundations, and federal and state government.
- Juniper may share information with your healthcare provider but only when your provider directly referred you. The information Juniper may share with your healthcare provider is limited to the status of whether you did or did not complete a class.
- Juniper may share information with your health plan but only when your health plan is paying a fee, if any is required, for your participation in a class. The information Juniper may share with your health plan is limited to the status of whether you did or did not complete a class, and further, may share your responses to class surveys. If your health plan is paying a fee for your participation, if any is required, you may be required to complete class surveys.
- Juniper will not sell your personal data to third parties to market or advertise to you.
- Juniper reserves the right to update or modify our Privacy Policy, and when we do so we will update the effective date. Your continued participation in a class constitutes your agreement to our Privacy Policy.

I agree to the terms of the Privacy Policy.

Participant Signature Date

Fall Prevention: Participant Information Form

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): __ __ __ __ __ __

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1. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?

   O Yes O No

2. How old are you today? _____years

3. Do you live alone? O Yes O No

4. Are you: O Male or O Female?

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

6. What is your race? **Check all that apply**.
   - O American Indian or Alaska Native
   - O Asian
   - O Black or African American
   - O Native Hawaiian or other Pacific Islander
   - O White

7. What is the highest grade or level of school that you have completed?
   - O Less than high school
   - O Some high school
   - O High school graduate or GED
   - O Some college or vocational school
   - O College graduate or higher

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)? (**Please check all that apply**.)

   - ☐ Arthritis or other bone/joint disease
   - ☐ Breathing/lung disease
   - ☐ Depression
   - ☐ Diabetes
   - ☐ Heart disease or blood circulation problem
   - ☐ Glaucoma/ other chronic eye problem
   - ☐ Other chronic condition: _____
   - ☐ None (No chronic conditions)

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

Participant Information Form (continued)

9. Are you limited in any way in any activities because of physical, mental, or emotional problems?

   O Yes O No

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? O none O _____times

    a. If you fell in the past 3 months, 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

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	○	○	○	○
b. I can find a way to reduce falls	○	○	○	○
c. I can protect myself if I fall	○	○	○	○
d. I can increase my physical strength	○	○	○	○
e. I can become more steady on my feet	○	○	○	○

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

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Fall Prevention: Participant Supplement Form

Please indicate your insurance provider:

○ Aetna ○ Blue Cross Blue Shield of MN ○ HealthPartners ○ Humana ○ Medica

○ PreferredOne ○ UCare ○ Other: _____

Are you currently on Medicare? ○ Yes ○ No ○ Unknown

What is the name of your primary physician: _____

What is your primary healthcare organization: _____

How did you hear about this class?

○ Physician ○ Care Coordinator ○ Community Organization ○ Family member/friend

○ Insurance company ○ Other: _____

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1. As you begin this class, how well do you feel you understand what is involved in this program?
   ○ Extremely well ○ Quite well ○ Moderately well ○ Slightly well ○ Not at all well

2. In general, I would say that my sense of well-being is:
   ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

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

   _____

   _____

   _____
