OMB Control No. 0985-0039
Exp. Date 04/30/2024

A Matter of Balance Participant Post Program Survey

By filling out this form, I agree that the information collected on programs forms may be studied and shared, with no way to link it back to me.

Admin Use Only: *Participant I.D.:* The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.

State abbreviation: __ __ (e.g., NY, VA, etc.)
First four letters of the site name: __ __ __ __
Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)
Participant number: __ __ (e.g., 01, 02, 03, etc.)

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)*

      ☐ 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

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Participant Post Program Survey (continued)

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 level of activity?

- ◯ 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.	☐	☐	☐	☐	☐

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