A Matter of Balance Course

***Instructions to the Leaders/Coaches/Instructors*: Please use this as a cover sheet for the completed data collection forms to return to the Survey Coordinator at the end of the program.**

1. Site Name:____

   City: ____State: ____________

2. If this is a new program delivery/ implementation site, please also complete 2a and 2b:

   a. Street Address: ____Zip code:___________

   b. Type of site (select the type that best describes your site):

O Municipal Government	O Recreational Organization
O Area Agency on Aging	O Residential Facility
O County Health Department	O Senior Center
O Educational Institution	O Other Community Center
O Faith-based Organization	O Tribal Center
O Health Care Organization	O Workplace
O Library	O Other (please specify):
O Multi-purpose social services organization	

3. Name of parent/host/sponsoring organization licensed to offer program: ______________________

4. Leader/Coach/Instructor Names (Please provide your first and last names and provide the daytime phone number or email of the best person to contact about any questions on the forms.)

   Name: __________________________ Phone __________________Email:___________________

   Name:___________________________Phone :_________________Email:___________________

5. Program Start Date (mm/dd/yyyy): ________________End Date (mm/dd/yyyy): _______________

6. Did you offer a "Session 0" with this workshop? (Session 0 is an optional pre-workshop session provided by some agencies.) Yes ☐ No☐

7. What type of program is this? (Mark only one.)

O A Matter of Balance	O YMCA Moving for Better Balance program
O Stepping On	O Tai Chi: Moving for Better Balance
O Stay Active and Independent for Life	O Other—list name:

A Matter of Balance Attendance Log

Start Date: _ _/_ _/_ _ _ _ End Date: _ _/_ _/ _ _ _ _

Participant ID									
	1	2	3	4	5	6	7	8	TOTAL

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 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Administration for

A Matter of Balance
Participant Information Form

Today's date: ____/ ____/_________
M M D D YYYY

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
☐ Heart disease or blood circulation problem
☐ Breathing/lung disease
☐ Glaucoma/ other chronic eye problem
☐ Depression
☐ Other chronic condition: _____________
☐ Diabetes
☐ 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:
    O Excellent O Very good O Good O Fair O 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?
    O Not at all O A little O Somewhat O 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	O	O	O	O
b. I can find a way to reduce falls	O	O	O	O
c. I can protect myself if I fall	O	O	O	O
d. I can increase my physical strength	O	O	O	O
e. I can become more steady on my feet	O	O	O	O

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?

    O Extremely O Quite a bit O Moderately O Slightly O Not at all

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A Matter of Balance
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): __ __ __ __ __ __

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1. In general, would you say that your health is:
   O Excellent O Very good O Good O Fair O 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? O none O ____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?
   O Not at all O A little O Somewhat O A lot

4. Has this program reduced your fear of falling? O Yes O 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
f. I can find a way to get up if I fall	O	O	O	O
g. I can find a way to reduce falls	O	O	O	O
h. I can protect myself if I fall	O	O	O	O
i. I can increase my physical strength	O	O	O	O
j. I can become more steady on my feet	O	O	O	O

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

Participant Post Program Survey (continued)

6. During the <u>last 4 weeks</u>, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups?
   O Extremely   O Quite a bit   O Moderately   O Slightly   O 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	O	O	O	O
b. I feel more comfortable talking to my family and friends about falling	O	O	O	O
c. I feel more comfortable increasing my activity	O	O	O	O
d. I plan to continue exercising	O	O	O	O
e. I feel more satisfied with my life	O	O	O	O
f. I would recommend this program to a friend or relative	O	O	O	O

8. Since this program began, what have you done to reduce your chance of a fall?
   Check all that apply.
   - o Talked to a family member or friend about how I can reduce my risk of falling
   - o Talked to a health care provider about how I can reduce my risk of falling
   - o Had my vision checked
   - o Had my medications reviewed by a health care provider or pharmacist
   - o Participated in another fall prevention program in my community
   - o Did exercises I learned in this program at home
   - o Made changes in my home to reduce my risk of falling (for example, secured rugs or improved lighting)

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