

Tai Chi For Arthritis

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):

<input type="checkbox"/> Municipal Government	<input type="checkbox"/> Recreational Organization
<input type="checkbox"/> Area Agency on Aging	<input type="checkbox"/> Residential Facility
<input type="checkbox"/> County Health Department	<input type="checkbox"/> Senior Center
<input type="checkbox"/> Educational Institution	<input type="checkbox"/> Other Community Center
<input type="checkbox"/> Faith-based Organization	<input type="checkbox"/> Tribal Center
<input type="checkbox"/> Health Care Organization	<input type="checkbox"/> Workplace
<input type="checkbox"/> Library	<input type="checkbox"/> Other (please specify):
<input type="checkbox"/> 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.)

<input type="checkbox"/> A Matter of Balance	<input type="checkbox"/> YMCA Moving for Better Balance program
<input type="checkbox"/> Stepping On	<input type="checkbox"/> Tai Chi: Moving for Better Balance
<input type="checkbox"/> Stay Active and Independent for Life	<input type="checkbox"/> Tai Chi for Arthritis:

Tai Chi for Arthritis

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

Tai Chi for Arthritis Participant Information Form

Today's date: ____/____/_____
 M M D D YYY

Participant I.D. (first two letters of your first name, first two letters of your last name, last two numbers of your birth year): ____ __ __ __ __ __

1. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?
 Yes No

2. How old are you today? _____years

3. Do you live alone? Yes No

4. Are you: Male or Female?

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

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

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

<input type="checkbox"/> Arthritis or other bone/joint disease	<input type="checkbox"/> Heart disease or blood circulation problem
<input type="checkbox"/> Breathing/lung disease	<input type="checkbox"/> Glaucoma/ other chronic eye problem
<input type="checkbox"/> Depression	<input type="checkbox"/> Other chronic condition: _____
<input type="checkbox"/> Diabetes	<input type="checkbox"/> 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?

Yes 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? none ___ 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	<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"/>

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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Tai Chi for Arthritis

Participant Post Program Survey

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

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
f. I can find a way to get up if I fall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I can find a way to reduce falls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I can protect myself if I fall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I can increase my physical strength	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. 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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