Illinois Pathways to Health by AgeOptions

Falls Prevention Pre-Survey
Participant Information Form

Participant Number or Name: _____

Participant Date of Birth: __ __ / __ __ / __ __ (e.g., 12/01/21)

Workshop ID: __ __ (e.g., 01, 02, 03, etc.)

Provider Name: _____ (e.g., XYZ Organization)

Start date of program: ____ / ____ / ____ (e.g., 12/01/21)

Program Name:

☐ A Matter of Balance ☐ Tai Chi for Arthritis and Fall Prevention

☐ Bingocize*

***Bingocize Only:* Which Bingocize® unit are you participating in? Mark one answer.**

☐ Exercise-Only ☐ Nutrition

☐ Falls-Prevention ☐ Other: _____

How did you hear about this class?

☐ Physician or member of my healthcare team ☐ Care Coordinator

☐ Insurance Company ☐ Family member/friend

☐ Community Organization ☐ Other: _____

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1. Did your doctor or other health care provider suggest that you attend this program?
   ☐ Yes ☐ No

2. From what health system do you receive your primary healthcare care services?

Advocate Aurora Health		Mercy Health Corporation	
Amita Health		NorthShore University Health System	
Blessing Health System		Northwestern Memorial Health Care	
Carle Health		OSF Health Care	
Cook County Health		Presence Health	
Edward-Elmhurst Health		Rush	
Hospital Sisters Health System		Sinai Chicago	
Kindred Healthcare		Southern Illinois Healthcare	
Loyola Medicine		Swedish American Health System	
Memorial Health System			

3. How old are you today? __ years

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4. Do you live alone? ☐ Yes ☐ No

5. Are you: ☐ Male ☐ Female ☐ Prefer not to say

6. How would you describe your gender?

☐	Male	☐	Trans Female/Trans Woman
☐	Female	☐	Not listed above Please specify: _____
☐	Genderqueer/Gender Non-Conforming	☐	Decline to answer
☐	Trans Male/Trans Man		

7. What sex were you assigned at birth, such as on an original birth certificate?

☐	Male	☐	Intersex
☐	Female	☐	Decline to answer

8. Sexual orientation:

☐	Lesbian	☐	Straight
☐	Gay	☐	Something else
☐	Bisexual	☐	Questioning
☐	Queer	☐	Decline to answer

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

10. What is your race? **Check all that apply.**

☐	American Indian or Alaska Native	☐	Native Hawaiian or other Pacific Islander
☐	Asian	☐	White
☐	Black or African American		

11. What is the highest grade or level of school that you have completed?

☐	Some elementary, middle, or high school	☐	Some college or technical school
☐	High school graduate or GED	☐	College (4 years or more)

12. 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)?

	YES	NO		YES	NO
Alzheimer's Disease or other dementia	☐	☐	Hypertension (High Blood Pressure)	☐	☐
Anxiety Disorder	☐	☐	Kidney Disease	☐	☐
Arthritis/Rheumatic Disease	☐	☐	Obesity	☐	☐

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	YES	NO		YES	NO
Asthma/Emphysema/Other Chronic Breathing or Lung Problem	☐	☐	Osteoporosis (Low Bone Density)	☐	☐
Cancer or Cancer Survivor	☐	☐	Parkinson's Disease	☐	☐
Chronic Pain	☐	☐	Schizophrenia or Other Psychotic Disorder	☐	☐
Depression	☐	☐	Stroke	☐	☐
Diabetes (High Blood Sugar)	☐	☐	Traumatic Brain Injury	☐	☐
Heart Disease	☐	☐	Urinary Incontinence	☐	☐
High Cholesterol	☐	☐	Other Chronic Condition	☐	☐

13. In general, would you say that your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

14. 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.

15. In the past 3 months, how many times have you fallen? ☐ None ____times

If you fell in the past three months:

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

16. How fearful are you of falling?

☐ Not at all ☐ A little ☐ Somewhat ☐ A lot

17. 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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18. 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	☐	☐	☐	☐	☐

19. What best describes your activity level?

- ☐ Vigorously active for at least 30 min, 3 times per week
- ☐ Moderately active at least 3 times per week
- ☐ Seldom active, preferring sedentary activities

20. During the past year, did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability? ☐ Yes ☐ No

21. The UCLA 3-item Loneliness scale:

	Hardly ever	Some of the time	Often
a. How often do you feel that you lack companionship?	☐	☐	☐
b. How often do you feel left out?	☐	☐	☐
c. How often do you feel isolated from others?	☐	☐	☐