Illinois Pathways to Health by AgeOptions

Fit and Strong! Participant Post Program Survey

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: ☒Fit and Strong!

How did you hear about this class?

☐ Physician or member of my healthcare team
☐ Insurance Company
☐ Community Organization
☐ Care Coordinator
☐ Family member/friend
☐ Other: ____________________

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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)*

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Fit and Strong! Participant Post Program Survey

☐ 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

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 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

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.					

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Fit and Strong! Participant Post Program Survey

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

10. 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?	☐	☐	☐

11. The class helped me achieve the goals I set in my action plan(s):

☐ Yes ☐ No

12. Would you be willing to share your story to help other people gain access to these programs?

☐ Yes ☐ No

13. What is most valuable to you in this program?

____

____

____

14. Please provide any thoughts or feedback about the program leader(s):

____

____

____

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

____

____

____

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WOMAC Questions

The following questions concern the amount of pain you are currently experiencing in your hips and/or knees. For each situation, please indicate the amount of pain you recently experienced using the following scale: None, Mild, Moderate, Severe, Extreme. Select one number only.

22. How much PAIN do you have when:

	None	Mild	Moderate	Severe	Extreme
a. Walking on a flat surface	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. Going up or down stairs	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
c. At night while in bed	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
d. Sitting or lying	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
e. Standing upright	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

The following questions concern the amount of JOINT STIFFNESS (not pain) you are currently experiencing in your hips and/or knees. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints. Select one number only.

23. How severe is your STIFFNESS (not pain) after:

	None	Mild	Moderate	Severe	Extreme
a. First waking in the morning	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. Sitting, lying or resting later in the day	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you are currently experiencing due to arthritis in your hips and/or knees. Select one number only.

24. What degree of difficulty do you have with:

	None	Mild	Moderate	Severe	Extreme
a. Descending stairs (walking down)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. Ascending stairs (walking up)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
c. Rising from sitting	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
d. Standing	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
e. Bending to the floor	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
f. Walking on a flat surface	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
g. Getting in/out of a car	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
h. Going shopping	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

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Fit and Strong! Participant Post Program Survey

	None	Mild	Moderate	Severe	Extreme
i. Putting on socks/stockings	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
j. Rising from bed	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
k. Taking off socks/stockings	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
l. Lying in bed	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
m. Getting in/out of the bathtub	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
n. Sitting	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
o. Getting on/off the toilet	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
p. Heavy domestic duties	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
q. Light domestic duties	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐