new hampshire falls risk reduction task force

Participant Post Program Survey

Please fill out this form so we can learn more about you.
The information on this form will remain confidential.

SF1. Today's Date: __ __ / __ __ / __ __ __ __
m m d d y y y y

SF2. ID: Participant's first two letters first name, MI, First two letters of last name, and last two numbers of your birth year:

_____ _____ _____ _____ _____ _____ _____
First1 First2 Middle1 Last1 Last2 BirthYr3 BirthYr4

S3. Tai Chi class location: _____

S4. Date of birth: (Month/Day/Year) __ __ / __ __ / __ __ __ __
m m d d y y y y

S5. What is your gender? □ Male □ Female

S6F1. In general, would you say that your health is:

□ Excellent □ Very good □ Good □ Fair □ Poor

S7. Do you need help with one or more activities of daily living? (For example, bathing or dressing)

□ Yes □ No

S8. How satisfied are you with your current physical activity levels?

□ Very □ Mostly □ Somewhat □ Not at all

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.

S9. I feel confident that I can keep myself from falling.

□ Strongly Agree □ Agree □ Disagree □ Strongly Disagree

S10. How often do you restrict your activities because of difficulties in walking?

□ Never □ Seldom □ Sometimes □ Often

F2. Since this program began, how many times have you fallen? □ None □ _____# times

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.) **_____# of falls causing an injury**

S11. In the past 3 months, how many times have you fallen? □ None □ _____# times

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.) **_____# of falls causing an injury**

F3. How fearful are you of falling?

□ Not at all □A little □Somewhat □A lot

F4. Has this program reduced your fear of falling? □ Yes □ No

S12. Having taken this program will help me prevent falls in the future

□ Strongly Agree □ Agree □ Disagree □ Strongly Disagree

F5. Please check the box 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				
b. I can find a way to reduce falls				
c. I can protect myself if I fall				
d. I can increase my physical strength				
e. I can become more steady on my feet				

F6. During <u>the last 4 weeks</u>, 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

F7. Please tell us your thoughts about this program. <u>Check one square for each question</u>.

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.				
b. I feel more comfortable talking to my family and friends about falling.				
c. I feel more comfortable increasing my activity.				
d. I plan to continue exercising.				
e. I feel more satisfied with my life.				
f. I would recommend this program to a friend or relative.				

F8. Since this program began, what have you done to reduce your chance of a fall? <u>Check all that apply.</u>

□ 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)

ACTIVITIES-SPECIFIC BALANCE CONFIDENCE SCALE (ABC)

For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady by choosing one of the percentage points on the scale from 0% to 100%. If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity rate your confidence using the support.
For each of the following activites, please indicate your level of self-confidence by choosing a corresponding number from the following scale:

0% no confidence >>>>>>>>>>>>>>>>>> complete confidence 100%										
0%	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**

How confident are you that you will not lose your balance or become unsteady when you…

_____% 1 … walk around the house?

_____% 2 …walk up or down stairs?

_____% 3 …bend over and pick up a slipper from the closet floor?

_____% 4 …reach for a small can off a shelf at eye level?

_____% 5 …stand on tip toes and reach for something above your head?

_____% 6 …stand on a chair and reach for something?

_____% 7 …sweep the floor?

_____% 8 …walk outside the house to a car parked in the driveway?

_____% 9 …get into or out of the car?

_____% 10 …walk across the parking lot to the mall?

_____% 11 …walk up or down a ramp?

_____% 12 …walk in a crowded mall where people rapidly walk past you?

_____% 13 …are bumped into by people as you walk through the mall?

_____% 14 …step onto or off an escalator holding the railing?

_____% 15 …step onto or off an escalator while holding parcels such that you cannot hold onto the railing?

_____% 16 …walk outside on icy sidewalks?

This section to be completed by the Evaluator

Evaluator: See full copy of instructions for each measurement. Record the participant's scores on this page.

Evaluator's Name: _____ Date: _____

TIMED UP & GO (TUG) - 12 seconds or greater is considered a fall risk

Trial	Seconds
1 (Practice)	
2	
3	
	Average of trials two and three = _____ seconds (TUG score)

Walking Aid used? □ Yes □ No Type of aid: _____

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30 SECOND CHAIR STAND TEST – see STEADI age range average table for fall risk

Number of stands completed in 30 seconds: _____

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4 STAGE BALANCE TEST - Inability to hold tandem stance 10 seconds is considered a fall risk

1. Standing with feet side by — Times in _____ (seconds)

2. Instep of one foot so it is touching the big toe of the other (semi-tandem) — Times in _____ (seconds)

3. One foot placed in front of the other, heel Touching the toe (tandem) — Times in _____ (seconds)

4. Standing on one foot — Times in _____ (seconds)