Post-Program Survey

Tai Ji Quan: Moving for Better Balance, Matter of Balance, Stepping On, Stay Active and Independent for Life (SAIL)

Participant Number or Name:

_____

Provider Name (e.g. XYZ Organization):

Program Name:_____

Today's date: _____/_____/_____
MM DD YYYY

Participant Date of Birth: _____/_____/_____
MM DD YYYY

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1. In general, would you say 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?

   _____ times

   If you fell since this 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)
      ☐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. How sure are you 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 minutes, 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. **Select one box for each question:**

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.	☐	☐	☐	☐	☐

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 class helped me achieve the goals I set in my action plan(s) (person-centered plan): ☐ Yes ☐ No

11. Would you be willing to share your story to help other people gain access to these programs? ☐ Yes ☐ No

12. What was most valuable to you in this program?

_____

_____

_____

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

_____

_____

_____

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

_____

_____

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