

# A Matter of Balance - First Session Survey

Today's Date: Month\_\_\_\_\_Day\_\_\_\_\_Year\_\_\_\_\_

Your Name:\_\_\_\_\_

1. What is your date of birth?

Month\_\_\_\_\_Day\_\_\_\_\_Year\_\_\_\_\_

2. What is your zip code?\_\_\_\_\_

3. Today, how many people live in your household (including yourself)?\_\_\_\_\_

4. Are you?

Female Male Other\_\_\_\_\_

5. Are you of Hispanic, Latino, or Spanish origin?

Yes

No

Unknown

6. What is your race?(Mark all that apply.)

American Indian or Alaska Native

Asian or Asian-American

Black or African-American

Hawaiian Native or Pacific Islander

White or Caucasian

Other : \_\_\_\_\_

# A Matter of Balance – First Session Survey

**Falls Management:** Please check the box that tells us how sure you are that you can do the following activities. How sure are you that you can:

	Very Sure	Sure	Somewhat Sure	Not at all Sure
I can find a way to get up if I fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can find ways to reduce falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can protect myself if I fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can increase my physical strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can become more steady on my feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check ONLY ONE BOX to tell us how much you are walking or exercising now.

- I do not exercise or walk regularly now, and I do not intend to start.
- I do not exercise or walk regularly, but I have been thinking of starting.
- I am trying to start to exercise or walk.
- I have exercised or walked infrequently for over a month.
- I am doing moderate exercise less than 3 times per week.
- I have been doing moderate exercise 3 or more times per week.

# A Matter of Balance - Last Session Survey

Today's date: \_\_\_\_\_

Your

Name: \_\_\_\_\_

**Falls Management:** Please check the box that tells us how sure you are that you can do the following activities. How sure are you that you can:

	Very Sure	Sure	Somewhat Sure	Not at all Sure
I can find a way to get up if I fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can find ways to reduce falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can protect myself if I fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can increase my physical strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can become more steady on my feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Check ONLY ONE BOX to tell us how much you are walking or exercising now.

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- I am trying to start to exercise or walk.
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- I am doing moderate exercise less than 3 times per week.
- I have been doing moderate exercise 3 or more times per week.

## A Matter of Balance Class Evaluation

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**Name:**

**Date:**

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Thank you for participating in *A Matter of Balance*. To help us further meet the needs of others throughout the community, please take a few minutes to complete this evaluation form. We appreciate your feedback..

**Please tell us your thoughts about the A Matter of Balance class:**

Please circle answers that apply on the front and back of this page.

**1. The leaders were well prepared.**

Strongly Agree    Agree                      Disagree                      Strongly Disagree

**2. The classes were well organized.**

Strongly Agree    Agree                      Disagree                      Strongly Disagree

**3. The participant workbook helped me better understand the classes.**

Strongly Agree    Agree                      Disagree                      Strongly Disagree

**4. As a result of this class, I feel more comfortable talking with others about my fear of falling.**

Strongly Agree    Agree                      Disagree                      Strongly Disagree

**5. As a result of this class, I have made changes to my environment.**

Strongly Agree    Agree                      Disagree                      Strongly Disagree

## A Matter of Balance Class Evaluation

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**6. As a result of this class, I feel more comfortable increasing my activity.**

Strongly Agree    Agree                      Disagree                      Strongly Disagree

**7. As a result of this class, I plan to continue exercising.**

Strongly Agree    Agree                      Disagree                      Strongly Disagree

**8. I would recommend this class to a friend or relative.**

Strongly Agree    Agree                      Disagree                      Strongly Disagree

**9. Are you male or female?**

Male                      Female

**10. How old are you?**

Less than 60 years – 74 years	60 - 64 years	65 – 69 years	70
75 – 79 years	80 – 84 years	85- 89 years	
90 years and older			

**What other changes have you made as a result of this class?**

**Other comments or suggestions?**