PL Collects at Session 1

Participant First Session Survey

Participant Name/Identifier: _____

County: _____ Date: _____

1. Year of Birth: | | | | | (Year)

2. I am ☐ Female ☐ Male

3. I live alone ☐ Yes ☐ No

4. I am Hispanic or Latino ☐ Yes ☐ No

5. I am *(check all that apply)*

   ☐ American Indian or Alaska Native
   ☐ Asian (country of origin): _____
   ☐ Black or African-American
   ☐ Native Hawaiian or Other Pacific Islander (Filipino)
   ☐ White/Caucasian
   ☐ Other (country of origin): _____

6. Type of insurance (*check all that apply*)

   ☐ Medicare ☐ Private Insurance ☐ Medicaid

7. Did you or do you have any of the following conditions? (*check all that apply*)

   ☐ Arthritis/rheumatic disease ☐ Asthma ☐ Cancer
   ☐ Depression/anxiety ☐ Diabetes ☐ Emphysema or COPD
   ☐ Crohn's or ulcerative colitis ☐ Osteoporosis ☐ Over-active thyroid
   ☐ Heart disease ☐ Prolonged period of immobility
   ☐ Menopause before age 45 or prolonged absence of your period
   ☐ Other: _____

8. Which of the following best describes your overall health? (c*heck one*)

   ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

9. During the **past month**, how many days did poor physical or mental health prevent you from doing your usual activities such as self-care, work or recreation? _____ days

Continued on Next Page ⇨

10. Have you fallen in the last 6 months?

☐ Yes ☐ No If Yes, how many times? _____

11. Have you fallen and gotten hurt in the past year?

☐ Yes ☐ No If Yes, how many times? _____

11. Please circle the number that best describes your level of concern about falling.

Not worried at all Somewhat worried Very worried

0 1 2 3 4 5 6 7 8 9 10

12. Which of the following increases your concern about falling? (*check all that apply*)

☐ Going up or down stairs
☐ Tripping over rugs or clutter
☐ Walking up or down a steep incline
☐ Walking on uneven surfaces
☐ Walking on slippery or icy streets
☐ Taking medications that may cause dizziness
☐ Having poor vision or hearing
☐ Feeling unstable and losing my balance
☐ Reaching for things
☐ Not being able to get up after a fall
☐ Other: _____

13. Do you exercise regularly (30 minutes-a-day, 3 times-a-week)? ☐ Yes ☐ No
How often do you exercise?

Number of times a week: _____ Minutes each time: _____

What types of exercise do you do? (*check all that apply*)

☐ Walking ☐ Running/jogging ☐ Dancing ☐ Aerobics
☐ Tai Chi ☐ Biking ☐ Weight lifting ☐ Aquatics
☐ Yoga ☐ Other: _____

14. How many times have you had a bone density text (DXA)?

☐ Never ☐ One time ☐ 2-4 times ☐ 4 or more times

15. What were the results of your most recent bone density text (DXA)?

☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ I don't know

16. Was your vitamin D concentration measured in the past year? ☐ Yes ☐ No
If Yes, what were the results?

☐ Normal ☐ Low ☐ I don't know Level (if known): _____