



Participant Last Session Survey

Participant Name/Identifier: _____

County: _____ Date: _____

- Do you feel your overall health has improved as a result of this program?
 Yes No
- 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
- Please indicate your overall progress and strength as a result of the Project Healthy Bones exercises. (*check all that apply*)

<input type="checkbox"/> Have better balance	<input type="checkbox"/> Have more stamina and energy
<input type="checkbox"/> Am more flexible	<input type="checkbox"/> Can walk further
<input type="checkbox"/> Can lift more weight	<input type="checkbox"/> No change
<input type="checkbox"/> Have increased strength in arms and legs	
- What changes have you made in your daily activities as a result of the Project Healthy Bones exercises? (*check all that apply*)

<input type="checkbox"/> Am more aware of my posture	<input type="checkbox"/> Am more active
<input type="checkbox"/> Can exercise more	<input type="checkbox"/> Can do more chores
<input type="checkbox"/> Am more careful about bending	<input type="checkbox"/> Other: _____
- 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
- Do you plan to continue to do the Project Healthy Bones exercises on your own?
 Yes No
- Do you have any comments about Project Healthy Bones? What changes would you recommend to the exercise or education elements?

8. Please describe how Project Healthy Bones has made a difference in your life.

9. Have you recommended Project Healthy Bones to a friend or family member?

- Yes No

10. Now that you've completed the program, what will you do to keep fit? If you plan to stay in your current class, please explain why.

11. What changes have you made as a result of participating in Project Healthy Bones? (*check all that apply*)

- Talked with my doctor about osteoporosis
- Talked with my doctor or pharmacist about my medications
- Stopped taking or modified the dose of medications that may weaken my bones (for example: corticosteroids)
- Started taking a medication for osteoporosis
- Stopped taking a medication for osteoporosis
- Had a DXA scan
- Had vitamin D concentration measured and it was (if known): _____
- Eat more calcium-rich foods
- Added/changed taking a calcium supplement
- Added/changed taking a vitamin D supplement
- Drink more water to improve hydration
- Changed my footwear
- Had my vision checked
- Had my hearing checked
- Made no changes
- Other: _____

12. **If you have not made any of these changes, please explain why.**
