

CWD - Bingocize Participant Post-Unit Form

BINGOCIZE - Pg 1

Please use the participant ID you created when taking the enrollment survey (the first 2 letters of your first name, the first 2 letters of your last name, and the last 2 digits of your birth year).

Participant ID *

First 2 letters of first name

First 2 letters of last name

Last 2 digits of birth year

(untitled)

1. Which Bingocize® session did you just complete?

☐ Exercise - Only ☐ Falls Prevention ☐ Nutrition

☐ Other -

2. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?

☐ Yes

☐ No

3. How old are you today?

years

4. Do you live alone?

☐ Yes ☐ No

5. Are you male or female?

☐ Male
☐ Female

(untitled)

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

☐ Yes
☐ No

7. What is your race? Mark all that apply.

<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or other Pacific Islander
<input type="checkbox"/> White	

8. What is the highest grade or level of school that you have completed?

- | | |
|---|---|
| <input type="radio"/> Less than high school | <input type="radio"/> Some college or vocational school |
| <input type="radio"/> Some high school | <input type="radio"/> College graduate or higher |
| <input type="radio"/> High school graduate or GED | |

9. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)?

	Yes	No
Arthritis or other bone/joint disease	<input type="radio"/>	<input type="radio"/>
Breathing / lung disease	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Heart disease or blood circulation problem	<input type="radio"/>	<input type="radio"/>
High blood pressure / hypertension	<input type="radio"/>	<input type="radio"/>
Glaucoma/other chronic eye problem	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>
Parkinson's Disease	<input type="radio"/>	<input type="radio"/>
Other chronic condition(s)	<input type="radio"/>	<input type="radio"/>

10. Are you limited in any way in any activities because of physical, mental, or emotional problems?

☐ Yes ☐ No

(untitled)

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

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

12. Over the last two weeks, how much have you been bothered by the feelings below

	0 (not at all)	1	2	3 (a little)	4	5	6	7	8	9 (severely)
a. Feeling sad, down, or uninterested in life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Not having the social support you feel you need	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.

13. Since this program began, how many times have you fallen?

- ☐ none ☐ # of times

If you fell since the 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. Where did the fall(s) occur?

- ☐ Indoor
- ☐ Outdoor
- ☐ Both indoors and outdoors

C. What happened after you fell and had an injury? (check all that apply)

- ☐ Went to the emergency room
- ☐ Visited my Primary Care Physician
- ☐ Was admit to the hospital
- ☐ Did not seek medical care

14. How fearful are you of falling?

- ☐ Not at all ☐ A little ☐ Somewhat ☐ A lot

15. Please mark the circle that tells us **how sure you are** that you can do the following activities.

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

(untitled)

16. 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

17. I have made safety modifications in my home, such as installing grab bars or securing loose rugs, to reduce my risk of falling

☐ True ☐ False

18. What best describes your activity level?

- ☐ Vigorously active for at least 30 min, 3 times per week
- ☐ Moderately active at least 3 times per week
- ☐ Seldom active, preferring sedentary activities

19. Please tell us your thoughts about the program.

Check one circle for each question.

	Strongly agree	Agree	Disagree	Strongly disagree
I feel more comfortable talking to my health care provider about my medications and other possible risks for	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel more comfortable talking to my family and friends about falling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel more comfortable increasing my activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel more satisfied with my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I would recommend this program to a friend or relative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. On a scale from 1-5, how satisfied were you with this workshop with 1 being “Very Dissatisfied” and 5 being “Very Satisfied”?

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	I don't know	Decline to answer
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

23. Have you participated in an in-person workshop series (e.g., exercise, health and wellness, falls prevention) in the past?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ Decline to answer

In the future would you prefer to attend workshop series to be done over the phone, on the internet, or in-person?

- ☐ Phone
- ☐ Internet
- ☐ In-person
- ☐ I don't know
- ☐ Decline to answer

24. Would you recommend this workshop to a family/friend?

- ☐ Yes
- ☐ No
- ☐ I don't know
- ☐ Decline to answer

25. On a scale from 1-5, how satisfied were you with the workshop leader with 1 being "Very Dissatisfied" and 5 being "Very Satisfied"?

Very Dissatisfied	Dissatisfied	Neutral	Satisfied	Very Satisfied	I don't know	Decline to answer
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thank You!

Thank you for taking our form. Your response is very important to us.

