Please fill in marks like this: ●

Form A

AMOB Registration Supplement

Date: _____

INSTRUCTIONS: Fill in the answers that BEST describe you.

You may leave any question blank if you are not comfortable answering it.

1. First Name: _____

2. Last Name: _____

3. What is your address?

_____ Street Address

_____ City

_____ County

_____ State

_____ Zip Code

4. What is your phone number? (__ __ __) __ __ __-__ __ __ __

5. What is your email address? _____

6. What is your date of birth? (MM-DD-YYYY) __ __ / __ __ / __ __ __ __

7. What is your primary language?

English O Spanish O Other: _____ O

8. What is your insurance coverage?

Medicare O Medicaid O Private Insurance O Veterans Benefits O None O Other: _____ O

9. Do you have a Medicare Advantage Plan? Yes O No O

If yes, with who? _____

10. How many people are in your household, including yourself? _____

11. Please indicate your monthly income. If you are married, please indicate the income that best represents your combined monthly income. $_____

Please fill in marks like this: ●

Form A

12. Would you like to be contacted about future health care education classes and event?

Yes	No
O	O

13. Emergency Contact Information:

Name	Phone Number	Relationship
_____	_____	_____

14. Do you have a primary care doctor or health care provider?

Yes	No
O	O

15. If yes, please provide health care provider information

Name	Phone Number
_____	_____

16. Can we contact you by text?

Yes	No
O	O

I authorize the collaborators of this workshop to use this data for analysis to identify the benefits of this workshop for individuals with chronic diseases and their caregivers.

Your information will remain confidential:

_____

(Signature)

Please fill in marks like this: ●

Form B

AMOB Pre-Survey Supplement

First & Last Name: _____ **Today's Date:** _____

General Health

1. **Thinking about your *physical health*, which includes physical illness and injury, for *how many days* during the past 30 days was your *physical health* NOT good?**

   O Number of Days: _____

   O None

2. **Thinking about your *mental health*, which includes stress, depression, and problems with emotions, for *how many days* during the past 30 days was your *mental* health NOT good?**

   O Number of Days: _____

   O None

3. **During the past 30 days, for about *how many days* did *poor physical* or *mental health* keep you from doing your usual activities, such as self-care, work, or recreation?**

   O Number of Days: _____

   O None

Physical Activity

4. **Mark only one box to tell us how much you are walking or exercising now:**

   O I do not exercise or walk regularly now, and I do not intend to start

   O I do not exercise or walk regularly, but I have been thinking of starting

   O I am trying to start to exercise or walk.

   O I have exercised or walked infrequently for over a month

   O I am doing moderate exercise less than 3 times per week

   O I have been doing moderate exercise 3 or more times per week

Please fill in marks like this: ●

Form B

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.

Fall History		
5. In the past 3 months, how many TIMES did you go to a hospital or emergency department due to a fall or fall-related injury?	_____ Times	
6. In the past 3 months, how many TIMES were you hospitalized for one night or longer due to a fall or fall-related injury?	_____ Times	
7. In the past 3 months, how many NIGHTS did you spend in the hospital due to a fall or fall-related injury?	_____ Nights	
8. During the last 30 days, were you hospitalized overnight due to a fall?	Yes O	No O
9. How many different times did you stay in any hospital overnight or longer during the past 30 days due to a fall?	_____ Times	
10. How many nights were you in the hospital during the past 30 days due to a fall?	_____ Nights	
11. During the past 30 days, did you see a doctor or other healthcare professional at an emergency room due to a fall? (Do not include times you stayed in hospital overnight)	Yes O	No O

I authorize the collaborators of this workshop to use this data for analysis to identify the benefits of this workshop for individuals with chronic diseases and their caregivers.

Your information will remain confidential:

_____

(Signature)

[Program Name] Participant Information Form

OMB Control No. 0985-0039
Exp. Date 03/31/2021

Today's date: ____/ ____/_____
M M D D Y Y Y Y

Participant I.D. __ __ /__ __/ __ __ (first two letters of your first name, first two letters of your last name, last two numbers of your birth year)

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

O Yes O No

2. How old are you today? _____years

3. Do you live alone? O Yes O No

4. Are you: O Male or O Female?

5. Are you of Hispanic, Latino, or Spanish origin? O Yes O No

6. What is your race? **Check all that apply**.

O American Indian or Alaska Native
O Asian
O White
O Black or African American
O Native Hawaiian or other Pacific Islander

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

O Less than high school
O Some high school
O High school graduate or GED
O Some college or vocational school
O College graduate or higher

8. 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)? **Check Yes or No.**

Arthritis or other bone/joint disease	OYes ONo	High blood pressure/hypertension	OYes ONo
Breathing/lung disease	O Yes O No	Glaucoma/other chronic eye problem	OYes ONo
Cancer	O Yes O No	Osteoporosis	OYes ONo
Depression	O Yes O No	Parkinson's Disease	OYes ONo
Diabetes	O Yes O No	Other Chronic Condition(s) (specify):	_____ _____ _____
Heart disease or blood circulation problem	OYes O No		

9. Are you limited in any way in any activities because of physical, mental, or emotional problems? O Yes O No

Please turn this paper over and fill out the other side.

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

○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

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.

11. In the past 3 months, how many times have you fallen? O none O _____times

If you fell in the past 3 months:

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 (*Please check all that apply)?*

○ Indoors ○ Outdoors ○ Both indoors and outdoors

c. what happened after you fell and had an injury? *(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 _____

12. How fearful are you of falling?

○ Not at all ○ A little ○ Somewhat ○ A lot

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

How sure are you that:

	Very Sure	Sure	Somewhat sure	Not at all sure
a. I can find a way to get up if I fall	O	O	O	O
b. I can find a way to reduce falls	O	O	O	O
c. I can protect myself if I fall	O	O	O	O
d. I can increase my physical strength	O	O	O	O
e. I can become more steady on my feet	O	O	O	O

14. 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

15. 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

16. What best describes your activity level?

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