Information about data collected in this class

Welcome to Enhance®Fitness! We are so glad you have chosen to join this class.

Information about data collected for the National Falls Prevention Grant:
This EnhanceFitness class is made possible in part by a grant from the U.S. Administration for Community Living. This grant supports programs that are proven to help prevent falls.

As part of this grant we would like to ask you some questions. These questions are found on the following three pages, the National Falls Prevention Grant - Participant Information Form. You may choose not to answer any question. You will also be asked a similar set of questions after you have been in the program for about four months. The data from these questions help us understand the reach and impact of these fall-prevention programs and help us advocate to Congress for continued funding to support them. Data from these forms, along with other program enrollment forms that you will also be asked to complete further in this packet, will be entered into the *EnhanceFitness Online Data Entry System*, a secure online database which is managed by Sound Generations, the non-profit organization that also manages the national EnhanceFitness program. The data from the National Falls Prevention Grant - Participant Information Form will be reported to the *National Fall Prevention Database*, a secure online database managed by the National Council on Aging, for analysis. **The information reported to the National Fall Prevention Database is de-identified, and is NOT CONNECTED to any identifying information, such as your name, birthdate, address, phone number, etc.**

We follow very strict rules to protect all of your information and to keep it private. We will maintain the paper forms securely following standard practices for protecting private data. After a trained person enters your information into the secure online database, we will destroy the paper forms.

Do you agree to have your anonymous data from the Falls Prevention data collection forms shared with the National Council on Aging's National Fall Prevention database? **Initial:** Yes_____ or No _____

Please turn over to continue

Information about data collected for EnhanceFitness program management and evaluation:

On the pages after the National Falls Prevention Grant – Participant Information Form in this packet, there are additional forms that ask for personal information. This information assists your instructor and this EnhanceFitness class site with program management, such as contacting you with class scheduling information, and understanding your health status as it relates to exercising safely. These pages also ask for demographic information and fitness test information that helps your instructor, this class site, and Sound Generations, the non-profit organization that manages the national EnhanceFitness program, to understand who participates in this program and what impact the program has on those who participate.

You are not required to complete these forms to participate in this EnhanceFitness class. You may also choose to complete some questions and leave others blank.

Aggregated and de-identified data about who participates, how much people participate (from attendance tracked by instructors at each class session), and how fitness test scores change through time, are used by Sound Generations to evaluate the program, to report to funders, and to advocate for the program.

Your personally identifying information (such as name, birthdate, address, phone and email) will NOT be shared with anyone other than your instructor and site staff who are directly involved with managing this EnhanceFitness class. **We follow strict rules to protect all of your information and to keep it private.**

274-351

Consent Form – Evidence-Based Programs

AUTHORIZATION FOR THE RELEASE AND EXCHANGE OF MEDICAL INFORMATION AND MEDICAL RECORDS

I, _____, permit TidalHealth Peninsula Regional
(Print Name)
Medical Center, its providers, Peninsula Home Care, the MAC, Inc. Living Well Center of Excellence to share information about me, such as my medical condition, blood pressure readings and any other necessary information with people who help with my care, including physicians, nurses, therapists, health care agencies, state or federal agencies.

I also specifically authorize any health care provider or health care facility that has provided care to me to share any information requested by Wicomico County Health Department. Those providers who may release the requested information includes: physicians, nurses, therapists, health care agencies, hospitals and state or federal agencies.

I understand that my participation is voluntary and that signing this consent form is optional and not required for participation in a community workshop. In addition, I understand that I may revoke this authorization at any time by notifying MAC, Inc. Living Well Center of Excellence in writing.

A copy of this authorization with my signature may be used with the same effect as an original.

This authorization will expire one (1) year from date unless otherwise specified.

_____ _____

Date Signature of Patient or Authorized Representative

Telephone Number _____ Last 4 digits of Social Security # _____

Date of Birth _____

ENHANCE® FITNESS Participant Information Form

Office Use:
Class (site name and time): _____

Please print the following:

Name (first, middle initial, last) _____

Is there a nickname that you prefer to use? _____

Birthdate (MM/DD/YYYY) _____ /_____ /_____

Street: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____

Email: _____

How did you hear about EnhanceFitness? _____

What is your current marital status?

- ○ Single (never married)
- ○ Partnered (living with someone)
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed or Widowered

How many people live in your household (including yourself)? _____

How many children (under age 18) live in your household? _____

Do you now have any health problem that requires you to use special equipment, such as a cane, wheelchair, special bed or special telephone? ○ Yes ○ No

Have you ever served on active duty in the U.S. Armed Forces, Military Reserves, or National Guard? ○ Yes ○ No

OMB Control No. 0985-0039
Exp. Date 04/30/2024

Falls Prevention Program Participant Information Form

Admin Use Only: ***Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.
State abbreviation: __ __ (e.g., NY, VA, etc.)
First four letters of the site name: __ __ __ __
Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)
Participant number: __ __ (e.g., 01, 02, 03, etc.)

1. Did your doctor or other health care provider suggest that you attend this program?
   ☐ Yes ☐ No

2. How old are you today? __years

3. Do you live alone? ☐ Yes ☐ No

4. Are you: ☐ Male ☐ Female ☐ Prefer not to say

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

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

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

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

☐	Some elementary, middle, or high school
☐	High school graduate or GED
☐	Some college or technical school
☐	College (4 years or more)

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)?

	YES	NO		YES	NO
Alzheimer's Disease or other dementia			Hypertension (High Blood Pressure)		
Anxiety Disorder			Kidney Disease		
Arthritis/Rheumatic Disease			Obesity		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Parkinson's Disease		
Chronic Pain			Schizophrenia or Other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Traumatic Brain Injury		
Heart Disease			Urinary Incontinence		
High Cholesterol			Other Chronic Condition		

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Participant Information Form (continued)

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

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

10. How often do you feel lonely or isolated from those around you?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

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? ☐ None ____times

If you fell in the past three 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. Did you tell anyone, such as a family member, friend, or healthcare provider about this fall, whether or not it resulted in an injury?

☐ Yes ☐ No

c. what happened after you fell? *(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. 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?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

14. Please use an **X** to tell us how sure you are that you can do the following activities.

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

15. 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

ENHANCE® FITNESS Health History Form

Thank you for taking the time to complete this form. Please print your answers to the questions on both sides of this form. While you may leave any question blank, we encourage you to complete the form. It provides essential information about your health and fitness level to your Instructor.
All your answers will be kept strictly confidential.

Your Name: _____

Your Home Phone: (_____) _____ - _____

Emergency Contact Information:

Name/ relationship: _____/ _____

Phone: (_____) _____ - _____

What medications do you take?_____

_____

Do you have any allergies to food or medications? If yes, please list: _____

_____

What do you wish to accomplish by participating in this exercise program?

_____

_____

Your Doctor's Name: _____

Doctor's Phone: (_____) _____ - _____

Clinic Name, Mailing Address: _____

City: _____ State: _____ Zip: _____

Chronic Conditions

Have you ever been told by a doctor or other health professional that you have any of the following conditions? (Mark all that apply.)

- ❑ Arthritis
- ❑ Rheumatic disease
- ❑ Cancer
- ❑ Diabetes
- ❑ Prediabetes
- ❑ Depression
- ❑ Heart disease
- ❑ Hypertension
- ❑ Lung disease/ Breathing problems

OR

- ❑ No chronic conditions

Please turn over to continue

Other Conditions

Do you have history of any of the following? (Mark all that apply. If yes, note year it began.)

- ❑ Alzheimer's Disease
- ❑ Artificial joint (where?_____)
- ❑ Back problems
- ❑ Blackouts
- ❑ Broken bones
- ❑ Chest pain/ angina
- ❑ Cholesterol > 240
- ❑ Congestive heart failure
- ❑ Dizziness or blurred vision
- ❑ Double vision
- ❑ Emphysema
- ❑ Fall(s)
- ❑ Foot/ ankle swelling
- ❑ Heart attack
- ❑ Heart surgery
- ❑ Hernia
- ❑ Irreg./rapid heart beats
- ❑ Knee injuries
- ❑ Macular degeneration
- ❑ Memory loss
- ❑ Multiple sclerosis
- ❑ Osteoporosis
- ❑ Pacemaker/ defib.
- ❑ Parkinson's
- ❑ Poor leg circulation (left / right / both?)
- ❑ Seizures or epilepsy
- ❑ Severe headaches
- ❑ Shortness of breath
- ❑ Smoking (#/ day_____)
- ❑ Stroke
- ❑ Surgery in past year
- ❑ Unsteadiness
- ❑ Weakness

Other conditions or additional information: _____
_____

Self-Assessment

Do you believe you are physically fit?	☐ Yes	☐ No
Are you happy with your current weight?	☐ Yes	☐ No
Can you stand up from a chair without using the arms?	☐ Yes	☐ No
Can you get up from the floor without assistance?	☐ Yes	☐ No
Can you stand on one leg without support?	☐ Yes	☐ No
Can you walk up and down steps without using the handrail?	☐ Yes	☐ No
Can you walk around a city block without being short of breath?	☐ Yes	☐ No

What exercise do you currently do on a regular basis? (Please mark and state number of times per week next to the exercise)

- ❑ Walk
- ❑ Bike
- ❑ Skate
- ❑ Martial Arts
- ❑ Jog
- ❑ Dance
- ❑ Tai-Chi
- ❑ Aerobics
- ❑ Row
- ❑ Swim
- ❑ Tennis
- ❑ Other_____
- ❑ Yoga
- ❑ Stretch
- ❑ Weight Lift

_____

I, _____, hereby acknowledge that all the above information is true. I release Sound Generations (Seattle, WA) and all of its agents from all liability for any accident, injury or damages of any kind to persons or property that might occur while I participate in an Enhance®Fitness class.

Signature: _____ *Date:* _____

ENHANCE® FITNESS Fitness Checks

For Office Use:
Class (site name and time): _____

Name (first, middle initial, last) _____

Today's Date (MM/DD/YYYY) _____ /_____ /_____

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1. Has this program improved your physical abilities (walking, bending, strength, moving around, doing the activities you want to do)?

   No improvement ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 Great improvement

   Not applicable (new participant) ○

2. Including the days that you go to EnhanceFitness class, how many days per week do you do physical activity that is about as hard as EnhanceFitness exercises, for 30 minutes or more?

   ○ None ○ 1 day ○ 2 days ○ 3 days ○ 4 days ○ 5 or more days

3. Do you do any Level I (modified) exercises during EnhanceFitness classes?

   ○ Yes ○ No

Please turn over to continue

Standard Fitness Checks

Chair stand: _____ (# of STANDS in **30 seconds**)

○ Unable to do one chair stand, even with assistance

Arm curl: _____ (# of REPS in **30 seconds**)

○ 5 lb (Female)
○ 8 lb (Male)
○ Unable to lift required weight

○ Right arm or
○ Left arm?

8-foot Up-and-go: _____ (# of SECONDS to complete **one circuit**. Record to one decimal place.)

○ Used walker, cane or other assistive device

Important Confidentiality Notice

Information collected by Project Enhance (a program of Sound Generations, Seattle, WA) is used to improve EnhanceFitness (EF) and may be shared with researchers working with EF. In order to keep your information confidential (as provided by law), information about you will be assigned a code number, and researchers will not have access to any of your identifying information (such as your name, address or phone number).

My initials at the end of this sentence indicate that I DO NOT give my permission for my information to be given to researchers assisting EF with program evaluation and improvement: _____ (initial here if you DO NOT give permission)

Information about data collected for the National Falls Prevention Grant

As you may recall, this EnhanceFitness class is made possible in part by a grant from the U.S. Administration for Community Living. This grant supports programs that are proven to help prevent falls.

When you enrolled, you agreed to answer some questions to help us understand the reach and impact of these fall-prevention programs and help us advocate to Congress for continued funding to support these programs.

The questions on the following pages (the National Falls Prevention Grant - Post Program Survey), ask about how your participation in this program may have affected your risk of falling. Data from this form will be entered into the *EnhanceFitness Online Data Entry System*, a secure online database which is managed by Sound Generations, the non-profit organization that manages the national EnhanceFitness program. The data from the National Falls Prevention Grant - Post Program Survey will be reported to the *National Fall Prevention Database*, a secure online database managed by the National Council on Aging, for analysis. **The information reported to the National Fall Prevention Database is de-identified, and is NOT CONNECTED to any identifying information, such as your name, birthdate, address, phone number, etc.**

We follow very strict rules to protect all of your information and to keep it private. We will maintain the paper forms securely following standard practices for protecting private data. After a trained person enters your information into a secure online database, we will destroy the paper forms.

Do you agree to have your anonymous data from the Falls Prevention data collection forms shared with the National Council on Aging's National Fall Prevention database? **Initial:** Yes_____ or No _____

Falls Prevention Program Participant Post Program Survey

Admin Use Only: ***Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.
State abbreviation: __ __ (e.g., NY, VA, etc.)
First four letters of the site name: __ __ __ __
Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)
Participant number: __ __ (e.g., 01, 02, 03, etc.)

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

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How often do you feel lonely or isolated from those around you?

   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

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.

3. Since this program began, how many times have you fallen? ☐ None ____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. Did you tell anyone, such as a family member, friend, or healthcare provider about this fall, whether or not it resulted in an injury?

      ☐ Yes ☐ No

   c. what happened after you fell? *(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

4. How fearful are you of falling?

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

5. 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?

   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

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Participant Post Program Survey (continued)

6. Please use an **X** to tell us how sure you are that you can do the following activities.

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

7. 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

8. Please use an **X** to tell us your thoughts about this program.

As a result of this program:	**Strongly Disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly Agree**
a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling.	☐	☐	☐	☐	☐
b. I feel more comfortable talking to my family and friends about falling.	☐	☐	☐	☐	☐
c. I feel more comfortable increasing my activity.	☐	☐	☐	☐	☐
d. I feel more satisfied with my life.	☐	☐	☐	☐	☐
e. I would recommend this program to a friend or relative.	☐	☐	☐	☐	☐
f. I have reduced my fear of falling.	☐	☐	☐	☐	☐
g. I plan to continue to exercise.	☐	☐	☐	☐	☐
h. I have made safety modifications in my home, such as installing grab bars or securing loose rugs.	☐	☐	☐	☐	☐

9. Since this program began, what have you done to reduce your chance of a fall? **Check all that apply**

- ☐ Talked to a family member or friend about how I can reduce my risk of falling
- ☐ Talked to a health care provider about how I can reduce my risk of falling
- ☐ Had my vision checked
- ☐ Had my medications reviewed by a health care provider or pharmacist
- ☐ Participated in or plan to participate in another fall prevention program in my community