

CWD Tai Chi Pre-Information Form

(untitled)

Participant ID *

First 2 letters of
first name

First 2 letters of
last name

Last 2 numbers of
birth year

(untitled)

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

☐ Yes

☐ No

2. How old are you today?

3. Do you live alone?

☐ Yes

☐ No



4. Are you male or female?

- ☐ Male
- ☐ Female

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

- ☐ Yes
- ☐ No

(untitled)

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?

- ☐ Less than high school
- ☐ Some high school
- ☐ High school graduate or GED
- ☐ Some college or vocational school
- ☐ 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)?

	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"/>
Glaucoma/other chronic eye problem	<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"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>
Parkinson's Disease	<input type="radio"/>	<input type="radio"/>
<input type="text" value="Enter another option"/>	<input type="radio"/>	<input type="radio"/>

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

- ☐ Yes
- ☐ No



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

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

(untitled)

11. 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.

In the past 3 months, how many times have you fallen?

- ☐ none
- ☐ number of times

12. How fearful are you of falling?

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

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

13. How sure are you that:

	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)

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?

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

Tai Chi Waiver / Release

Please sign in below to acknowledge the waiver / release for the *Tai Chi for Arthritis* program. *

Clear

Sign name using mouse or touch pad

Signature of

Today's Date *

