Stay Strong, Stay Healthy 

Pre-Course Survey

1. **Please provide the course information below:**
   Host Site Name _____
   Instructor name _____
   State _____
   County _____

2. **Participant ID** *(Instructor's LAST NAME, the year you participated in the class, and the LAST 4 digits of your phone number) Ex: Weitzel20201234)* _____

3. **Age** _____

4. **Gender** *(for program analysis and improvement)* _____

5. **I describe my knowledge, skills and understanding of strength training exercise as:**
   - ❑ Excellent
   - ❑ Good
   - ❑ Average
   - ❑ Poor
   - ❑ Terrible

6. **I use or have been advised to use an assistive device such as a cane or walker to get around safely.**
   - ❑ Yes
   - ❑ No

7. **If you answered yes to the question above, please explain when you use the assistive device:**
   - ❑ All of the time
   - ❑ As needed
   - ❑ Only outdoors
   - ❑ Other _____

Pre-Course Survey *continued*

8. I take medicine that sometimes makes me feel light-headed or more tired than usual.

- ❑ Yes
- ❑ No

9. How many DAYS per week do you currently engage in the following:

	None	1 day per week	2–3 days per week	4+ days per week
Strength training exercises	❑	❑	❑	❑
Aerobic activities susch as walking, biking, swimming, etc.	❑	❑	❑	❑
Stretching or flexibility exercises	❑	❑	❑	❑
Balance exercises such as yoga, or Tai Chi	❑	❑	❑	❑
Other physical activity, such as gardening or dancing	❑	❑	❑	❑

10. How many MINUTES per week do you currently engage in the following:

Strength training exercises _____

Aerobic activities such as walking, biking, swimming, etc. _____

Stretching or flexibility exercises _____

Balance exercises such as yoga, or Tai Chi _____

Other physical activity, such as gardening or dancing. _____

11. In the past 12 months, how many times have you NEARLY fallen? _____

12. In the past 12 months, how many times have you FALLEN? _____

13. If you have fallen, how many of these falls caused an injury? _____

14. If you have fallen, where did the falls occur? (*Please indicate if the falls occurred indoors and/or outdoors and where specifically on the line provided.*)

- ❑ Indoors _____
- ❑ Outdoors _____

15. If you have fallen, what happened after you fell and had an injury?

- ❑ Emergency Room Visit
- ❑ Saw my Primary Care Doctor
- ❑ Stayed in the Hospital
- ❑ Did not Seek Medical Care
- ❑ Other _____

16. For each of the following activities please write in your level of self-confidence on a scale of 0 to 100%. *(Please use increments of 10. 0% corresponds to No Confidence and 100% corresponds to Completely Confident. If you do not currently do the activity, imagine how confident you would be if you had to do the activity. If you normally use an assistive device or hold onto someone to do the activity, rate your confidence as if you were using these supports.)*

How confident are you that you will NOT lose your balance or become unsteady when you...	**◄Not Confident** 0	10	20	30	40	50	60	70	80	90	**Completely Confident►** 100
Walk around the house?											
Walk up or down stairs?											
Bend over and pick up a slipper (or item) from the front of a closet floor?											
Reach for a small can off a shelf at eye level?											
Stand on your tiptoes and reach for something above your head?											
Stand on a chair and reach for something?											
Sweep the floor?											
Walk outside the house to a car parked in the driveway?											
Get into or out of a car?											
Walk across a parking lot to the mall (store)?											
Walk up or down a ramp?											
Walk in a crowded mall where people rapidly walk past you?											
Are bumped into by people as you walk through the mall?											
Step onto or off an escalator while you are holding onto a railing?											
Step onto or off an escalator while holding onto parcels (or other items) such that you cannot hold onto the railing?											
Walk outside on icy sidewalks?											

Pre-Course Survey *continued*

17. Please select "yes" or "no" for the following:

	Yes	No
I steady myself by holding onto furniture when walking at home.	❑	❑
I am worried about falling.	❑	❑
I need to push with my hands to stand up from a chair.	❑	❑
I have some trouble stepping up onto a curb.	❑	❑
I often have to rush to the toilet.	❑	❑
I have lost some feeling in my feet.	❑	❑
I take medicine to help me sleep or improve my mood.	❑	❑
I often feel sad or depressed.	❑	❑

18. Over the past 7 days, how much did pain interfere with your normal work (including both work outside the home and housework)?

- ❑ A great deal
- ❑ A lot
- ❑ A moderate amount
- ❑ A little
- ❑ None at all

19. During the past two weeks have you participated in any social activities such as contact with friends and neighbors or family, or attended a religious or other group event?

- ❑ Yes
- ❑ No
- ❑ No due to COVID

For the following questions please indicate your consumption for an average week. If you do not eat a certain food, please select "Does not apply to me."

In an average week, how often do you:	**Usually / Often**	**Sometimes**	**Rarely / Never**	**Does not apply to me**
20. Skip breakfast?	❑	❑	❑	❑
21. Eat 4 or more meals from sit-down or take out restaurants?	❑	❑	❑	❑
22. Eat less than 2 servings of whole grain products or high fiber starches a day? **Serving** = 1 slice of 100% whole grain bread; 1 cup whole grain cereal like Shredded Wheat, Wheaties, Grape Nuts, high fiber cereals, oatmeal, 3–4 whole grain crackers, ½ cup brown rice or whole wheat pasta, boiled or baked potatoes, yuca, yams or plantain.	❑	❑	❑	❑
23. Eat less than 2 servings of fruit a day? **Serving** = ½ cup or 1 med. fruit or ¾ cup 100% fruit juice.	❑	❑	❑	❑
24. Eat less than 2 servings of vegetables a day? **Serving** = ½ cup vegetables, or 1 cup leafy raw vegetables.	❑	❑	❑	❑
25. Eat or drink less than 2 servings of milk, yogurt, or cheese a day? **Serving** = 1 cup milk or yogurt; 1½–2 ounces cheese.	❑	❑	❑	❑
26. Eat more than 8 ounces (see sizes below) of meat, chicken, turkey or fish per day? ***Note:*** *3 ounces of meat or chicken is the size of a deck of cards or ONE of the following: 1 regular hamburger, 1 chicken breast or leg (thigh and drumstick), or 1 pork chop.*	❑	❑	❑	Rarely eat meat, chicken, turkey or fish ❑
27. Use regular processed meats (like bologna, salami, corned beef, hotdogs, sausage or bacon) instead of low fat processed meats (like roast beef, turkey, lean ham; low-fat cold cuts/hotdogs)?	❑	❑	❑	Rarely eat processed meats ❑

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In an average week, how often do you:	**Usually / Often**	**Sometimes**	**Rarely / Never**	**Does not apply to me**
28. Eat fried foods such as fried chicken, fried fish, French fries, fried plantains, tostones or fried yuca?	❑	❑	❑	❑
29. Eat regular potato chips, nacho chips, corn chips, crackers, regular popcorn, nuts instead of pretzels, low-fat chips or low-fat crackers, air-popped popcorn?	❑	❑	❑	Rarely eat these snack foods ❑
30. Add butter, margarine or oil to bread, potatoes, rice or vegetables at the table?	❑	❑	❑	❑
31. Eat sweets like cake, cookies, pastries, donuts, muffins, chocolate and candies more than 2 times per day.	❑	❑	❑	❑
32. Drink 16 ounces or more of non-diet soda, fruit drink/punch or Kool-Aid a day? ***Note:*** *1 can of soda = 12 ounces*	❑	❑	❑	❑
	Yes		**No**	
33. You or a member of your family usually shops and cooks rather than eating sit-down or take-out restaurant food?	❑		❑	
34. Usually feel well enough to shop or cook.	❑		❑	
35. Are you willing to make changes in your eating habits in order to be healthier?	❑		❑	

Thank you very much for completing this survey. Your participation helps us improve programs to meet the needs of community members like yourself. It also helps us study the long-term effects of participating in programs such as Stay Strong, Stay Healthy and builds support for these programs to be offered in your community. Your time and effort is greatly appreciated. Thank you again. You will receive another survey like at the end of the program. Your participation is highly valuable. If you have any questions or concerns please contact Kelsey Weitzel at weitzelkj@missouri.edu or 573-882-2799.