Pre Survey for Participants

Participant Demographics and Background Characteristics	
Participant ID	_____ (to be assigned by RISE staff)
Date	_____
Age	How old are you today? ____ years
Sex	Are you: ❑ Male ❑ Female ❑ Prefer not to say
Ethnicity	Are you of Hispanic, Latino, or Spanish origin? ❑ Yes ❑ No
Race	What is your race? (select all that apply) ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or Pacific Islander ❑ White ❑ Some Other Race (Please Specify___)
Live Alone	Do you currently live alone? ❑ Yes ❑ No
Location/Rurality	Is your home located in? Check one of the following: ❑ The city ❑ The suburbs ❑ A rural area ❑ Prefer not to say ❑ Don't know
Are you eligible for Medicaid?	❑ Yes ❑ No ❑ Prefer not to say ❑ Don't know

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Chronic Conditions	Which of the following chronic conditions has a health care provider told you that you have (one that has lasted for 3 months or more)? *Select all that apply* ❑ Alzheimer's Disease or other dementia ❑ Anxiety Disorder ❑ Arthritis/Rheumatic Disease ❑ Asthma/Emphysema/Other Chronic Breathing or Lung Problem ❑ Cancer or Cancer Survivor ❑ Chronic Pain ❑ Depression ❑ Diabetes (high blood sugar) ❑ Heart Disease ❑ High Cholesterol ❑ Hypertension (high blood pressure) ❑ Kidney Disease ❑ Obesity ❑ Osteoporosis (low bone density) ❑ Parkinson's Disease ❑ Schizophrenia or Other Psychotic Disorder ❑ Stroke ❑ Traumatic Brain Injury ❑ Urinary Incontinence ❑ Other Chronic Condition ❑ None ❑ Prefer not to say					
Outcome Measures						
Activities of Daily Living / Disability	ADLs: What is your level of independence with the following?					
		Unable to do	**Able to do with a lot of difficulty**	**Able to do with moderate difficulty**	**Able to do with a little difficulty**	**Able to do with no difficulty**
	Bathing: The ability to wash oneself, including getting in and out of the shower or bathtub.					
	Dressing: The ability to choose appropriate clothing and					

	put them on and take them off.					
	Toileting: The ability to use the toilet, including managing personal hygiene.					
	Transferring: The ability to move from one position to another, such as transferring from a bed to a chair.					
	Continence: The ability to control bowel and bladder functions.					
	Feeding: The ability to feed oneself, including the physical act of eating					
	Mobility: The ability to move around one's home.					
Instrumental Activities of Daily Living / Disability						
		Not applicable	**Unable to do**	**Able to do with a lot of difficulty**	**Able to do with moderate difficulty**	**Able to do with a little difficulty**
	Transportation and shopping: The ability to shop for clothing and other items required for daily life, attend events,					

	and manage transportation, either via driving or by organizing other means of transport.					
	Managing finances: The ability to pay bills and manage financial assets.					
	Shopping and meal preparation: The ability to shop for groceries and prepare a meal.					
	Housecleaning and home maintenance: Cleaning kitchens after eating, maintaining living areas reasonably clean and tidy, and keeping up with home maintenance.					
	Managing communication with others: The ability to manage telephone and mail.					
	Managing Medications: The ability to obtain medications					

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	and take them as directed.						
Fear of Falling_a .	How fearful are you of falling? ❑ Not at all ❑ A little ❑ Somewhat ❑ A lot						
Fear of Falling_b	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						
Falls Efficacy Scale	How confident are you today that you can do the following activities without falling? Score 1-10: 1 = not confident at all; 10 = very confident						

	n/a	1	2	3	4	5	6	7	8	9	10
Take a bath or shower											
Reach into cabinets or closets											
Walk around the house											
Prepare meals not requiring carrying heavy or hot objects											
Get in and out of bed											
Answer the door or telephone											
Get in and out of a chair											
Getting dressed and undressed											
Personal grooming (i.e. washing your face)											
Getting on and off of the toilet											

History of Falls_a	In the past 3 months, how many times have you fallen? None _____times
History of Falls_b	If you fell in the past 3 months, how many of these falls caused an injury? (By 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 injury

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Self-Rated Health_a	In general, would you say your health is: ❑ Poor ❑ Fair ❑ Good ❑ Very good ❑ Excellent
Self-Rated Health_b	How much pain do you experience daily? ❑ None ❑ Slight ❑ Moderate ❑ Severe ❑ Extreme
Physical Activity	What best describes your activity level? ❑ Seldom active (preferring sedentary activity such as watching TV) ❑ Light-intensity activity (slow walk, cooking, light household chores) ❑ Moderate-intensity activity at least 3 times per week (brisk, walking, raking the yard) ❑ Vigorous-intensity activity at least 3 times per week (jogging, shoveling snow, fitness class)
Loneliness	How often do you feel lonely? ❑ Never ❑ Rarely ❑ Sometimes ❑ Often ❑ Always
Social Isolation	How often do you feel isolated from those around you? ❑ Never ❑ Rarely ❑ Sometimes ❑ Often ❑ Always
Mental Health	How would you rate your mental health, which includes feeling of anxiety and/or depression, on most days in the past month? ❑ Excellent ❑ Very Good ❑ Good ❑ Fair ❑ Poor
Assistive Devices	Do you use an assistive device such as a cane, walker, rollator, scooter, wheelchair, etc.? ❑ Yes, please specify_____ ❑ No