Fending off falls  
Post-Program Questionnaire

Please take a moment to fill out the post-program questionnaire for **Fending Off Falls***.* We greatly appreciate your thoughts about your experience.

**QUESTION RESPONSE (PLEASE CIRCLE BEST OPTION)**

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| I know steps I can take to decrease my chances of falling. | Not Sure |  | Somewhat Sure |  | Very Sure |
| I practice exercises that support my independence and decrease fall risk. | Never | Rarely | Sometimes | Often | Most Days |
| I can effectively identify items that present fall risk hazards in each area of a home. | Not Sure | 1-2 items in each area | 3-4 items in each area | 5-6 items in each area | 7 or more items in each area |
| I am aware of any physical conditions that impact my risk of falls. | Not Sure |  | Somewhat Sure |  | Very Sure |
| I am mindful of my body and aware of my surroundings. | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |
| I am confident in my ability to recover if I do experience a fall. | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree |

What did you like most about the **Fending Off Falls** program?

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What changes or additions would you recommend for the **Fending Off Falls** program?

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