The George Institute for Global Health
Sydney Medical School
Faculty of Medicine

Participant ID_____

Ongoing fall prevention behaviour after participation in the Stepping On program

Baseline questionnaire

Name:_____ Date:_____

1. What is your age? _____ **2.** What is your gender? Male / Female

3. What language do you speak at home? _____

4. What is your country of birth? _____

4a. If not born in Australia, at what age did you migrate to Australia? _____

5. What is your home postcode?_____

6. Who else lives at home with you?

☐ I live alone
☐ I live with my spouse only
☐ I live with my spouse & children
☐ I live with a child / children
☐ I live with relatives / friends
☐ Other

7. How many falls have you had in the past 12 months? _____
(Include any fall including a slip or trip in which you lost your balance and landed on the floor or ground or lower level)

8. If you have fallen in the past 12 months:

a) How many of these falls required medical attention?_____
b) How many of these falls resulted in a fracture?_____

9. Do you have / have you ever had any of the following medical conditions?
(Please circle yes or no for each)

Arthritis (Rheumatoid/ osteo)	*Yes / No*	High blood pressure	*Yes / No*
Osteoporosis	*Yes / No*	Diabetes	*Yes / No*
Gastrointestinal disease (e.g. ulcer, hernia, reflux)	*Yes / No*	Asthma	*Yes / No*
Cognitive impairment / dementia	*Yes / No*	Stroke / TIA	*Yes / No*
COPD / emphysema	*Yes / No*	Depression	*Yes / No*
Angina/ heart disease/ heart attack	*Yes / No*	Gout	*Yes / No*
Congestive heart disease	*Yes / No*	Anxiety /panic disorder	*Yes / No*
Visual impairment	*Yes / No*	Cancer	*Yes / No*
Peripheral vascular disease	*Yes / No*	Hearing impairment	*Yes / No*
Atrial fibrillation	*Yes / No*		

10. When did you commence *Stepping On*? Month_____ Year_____

11. Suburb/ town of *Stepping On* group you attend_____

12. What is the main reason for you taking part in the *Stepping On* program?

_____

13. How did you find out about the *Stepping On* program?

☐ Friend / family member ☐ Doctor ☐ Other health professional

☐ Newsletter ☐ Poster / brochure ☐ Radio ☐ Newspaper article

☐ Other source, please specify _____

14. Physical Activity (Incidental and Planned Exercise Questionnaire)

a) In the past three months, how much time did you spend in the following physical activities on average per week?

Never [ ] (*please go to question b*)

Activity type	Number of times/week	Number of minutes per session				
		<30	30-45	45+	1-2hrs	2-4hrs
Exercise class	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Home activity (e.g. stationary bicycle, stretching)	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Other activity 1 (please specify)	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Other activity 2 (please specify)	_____	[ ]	[ ]	[ ]	[ ]	[ ]
Other activity 3 (please specify)	_____	[ ]	[ ]	[ ]	[ ]	[ ]

b) During the past three months, how often have you been on walks specifically for activity on average per week? (i.e. walking in the park, in the streets, cross-country walking, walking the dog etc).

Every day [ ]
3-6 times/week [ ]
Twice/week [ ]
Once/week [ ]
Less than once/week [ ]
Never (*please go to question d*) [ ]

c) In these walks for activity, how long did you walk for?

Less than 15mins/day [ ]
15mins to less than 30mins/day [ ]
30mins to less than 1 hour/day [ ]
1 hour to less than 2 hours/day [ ]
2 hours to less than 4 hours/day[ ]
4 or more hours/day [ ]

d) During the past three months, how often have you been on other walks (i.e. walk to general practitioner, pharmacy, or store) on average per week.

Every day [ ]
3-6 times/week [ ]
Twice/week [ ]
Once/week [ ]
Less than once/week [ ]
Never (*please go to question f*) [ ]

e) In these other walks, how long did you walk for?

Less than 15mins/day [ ]
15mins to less than 30mins/day [ ]

30mins to less than 1 hour/day [ ]
1 hour to less than 2 hours/day [ ]
2 hours to less than 4 hours/day[ ]
4 or more hours/day [ ]

f) In the past 3 months, in addition to the walking you mentioned above, how much time did you spend each day out of your house doing other physical activity such as house maintenance and gardening? (Excluding housework & activities inside house) Never (i.e. no garden) [ ]

Less than 15mins/day [ ]
15mins to less than 30mins/day [ ]
30mins to less than 60mins/day [ ]
1 hour to less than 2 hours/day [ ]
2 hours to less than 4 hours/day[ ]
4 or more hours/ day [ ]

g) In the past three months, how many hours did you spend on your feet each day indoors at home doing tasks like housework, self care or care for another person?

Never (i.e. living in hostel, assisted living) [ ]
Less than 15mins/day [ ]
15mins to less than 30mins/day [ ]
30mins to less than 60mins/day [ ]
1 hour to less than 2 hours/day [ ]
2 hours to less than 4 hours/day [ ]
4 or more hours/day [ ]

15. Prior to starting the *Stepping On* program were you already using any strategies to reduce your risk of falling? *Please tick all that apply:*

☐ I was regularly taking part in strength and balance exercises

☐ I have had cataract surgery

☐ I use some safe walking strategies (e.g., heel-toe walking, scanning ahead as I walk, non-glare sunglasses for outdoors)

☐ I have installed better lighting in the home

☐ I changed the environment at home to improve safety (such as non-slip strips on step edges, installed grab rails, outdoor sensor lights, removed some of the clutter in walkways etc)

☐ I have seen my GP or pharmacist to review my medications and discuss how to manage medications that may increase risk of falls

☐ I take a Vitamin D supplement

☐ I have checked my shoes and slippers to make sure they fit well and the soles are not too slippery

☐ Other, please specify_____

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16. The Falls Behavioural (FaB) Scale for the Older Person

The FaB scale is a list of 30 statements that describes things we do in our everyday lives. Please read each statement carefully. Circle how much each statement describes the things you do in your daily life. For example:

Never	Some-times	(Often)	Always

Only circle 'Doesn't apply' if the situation is something to which you are not exposed to (for example, if you do not have a phone)

Would this describe the things you do in your daily life?	**Circle which one applies**				
1. When I stand up I pause to get my balance	Never	Some-times	Often	Always	
2. I do things at a slower pace	Never	Some-times	Often	Always	
Would this describe the things you do in your daily life?	**Circle which one applies**				
3. I talk with someone I know about things I do that might help prevent a fall	Never	Some-times	Often	Always	
4. I bend over to reach something only if I have a firm handhold	Never	Some-times	Often	Always	Doesn't apply
5. I use a walking stick or walking aid when I need it	Never	Some-times	Often	Always	Doesn't apply
6. When I am feeling unwell I take particular care doing everyday things	Never	Some-times	Often	Always	Doesn't apply
7. I hurry when I do things	Never	Some-times	Often	Always	
8. I turn around quickly	Never	Some-times	Often	Always	
Now, these are things you do indoors					
9. To reach something up high I use the nearest chair, or whatever furniture is handy, to climb on	Never	Some-times	Often	Always	Doesn't apply
10. I hurry to answer the phone	Never	Some-times	Often	Always	Doesn't apply
11. I get help when I need to change a light bulb	Never	Some-times	Often	Always	
12. I get help when I need to reach something very high	Never	Some-times	Often	Always	
13. When I am feeling ill I take special care of how I get up from a chair and move around	Never	Some-times	Often	Always	Doesn't apply
14. When I am getting down from a ladder or step stool I think about the bottom rung/ step	Never	Some-times	Often	Always	Doesn't apply
Now, these are about lighting and eyesight					
15. I notice spills on the floor	Never	Some-times	Often	Always	
16. I use a light if I get up during the night	Never	Some-times	Often	Always	
17. I adjust the lighting at home to suit my eyesight	Never	Some-times	Often	Always	
18. I clean my spectacles	Never	Some-times	Often	Always	Doesn't apply

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Would this describe the things you do in your daily life?	Circle which one applies				
19. When wearing bifocals or trifocals I misjudge a step or do not see a change in floor level	Never	Some-times	Often	Always	Doesn't apply
Now, these are about shoes					
20. When I buy shoes I check the soles to see if they are slippery	Never	Some-times	Often	Always	
Now, these are things outdoors					
21. When I walk outdoors I look ahead for potential hazards	Never	Some-times	Often	Always	
22. I avoid ramps and other slopes	Never	Some-times	Often	Always	
23. I go out on windy days	Never	Some-times	Often	Always	
24. When I go outdoors I think about how to move around carefully	Never	Some-times	Often	Always	
25. I cross at traffic lights or pedestrian crossings whenever possible	Never	Some-times	Often	Always	Doesn't apply
26. I hold onto a handrail when I climb stairs	Never	Some-times	Often	Always	Doesn't apply
27. I avoid walking about in crowded places	Never	Some-times	Often	Always	
28. I keep shrubbery and plants trimmed back on the pathways to my front/ back doors	Never	Some-times	Often	Always	Doesn't apply
29. I carry groceries up the stairs only in small amounts	Never	Some-times	Often	Always	Doesn't apply
And, finally, these are about medications					
30. I ask my pharmacist or Dr questions about side effects of my medications	Never	Some-times	Often	Always	Doesn't apply

Thank you for completing this questionnaire