Island Senior Resources

www.senior-resources.org

(360) 321-1600

Stay Active & Independent for Life (SAIL)

a strength, balance, and fitness class for adults 65+

Participant Enrollment Form

Today's date: _____/____/_____
month / day / year

Your name: _____/____/_____
first name *MI* *last name*

Your address: _____
street address

_____ _____ _____
city *state* *zip code*

Your phone number: (_____) _____
area code *number*

Your email address: _____

Your physician/health provider's name: _____

Their phone number: (_____) _____
area code *number*

Your age (in years): _____ Date of birth: _____/____/_____
month / day / year

What is your gender? ❑ Male ❑ Female

What is your race? *(check all that apply)*

- ❑ White
- ❑ Black or African American
- ❑ American Indian and Alaska Native
- ❑ Asian
- ❑ Native Hawaiian and Other Pacific Islander
- ❑ Hispanic
- ❑ Other: _____

Do you take four or more medications on a daily basis (including over-the-counter medications)?

❑ Yes ❑ No

Please list your medications:

_____

_____

_____

_____

Do you regularly have one or more drinks of alcohol per day? ❑ Yes ❑ No

Within the past **3 years** has your doctor told you that you have any of the following problems?

During the past year, have you had any hip, knee, ankle or foot surgeries? ❑ Yes ❑ No

Condition	Yes	No	Don't Know
Arthritis of the knees			
Arthritis of the hips, knees, ankles			
Chronic Obstructive Pulmonary Disease (COPD)			
Emphysema			
Asthma			
Congestive heart failure			
Heart attack or other heart problems			
Thyroid problems			
Diabetes			
Parkinson's disease			
Cancer (not including skin cancer)			
Cataracts/glaucoma/macular degeneration			
High blood pressure/hypertension			
Epilepsy/seizures			
Back problems			
Peripheral neuropathy (including loss of feeling in feet or hands)			
Stroke			
Hip fracture			
Low blood pressure			
Osteoporosis (brittle bones)			
Hearing problems			
Other:			

What, if any, assistive devices do you use (check all that apply)?

- ❑ None
- ❑ Cane
- ❑ Walker
- ❑ Wheelchair/cart
- ❑ Other: _____

Have you fallen in the past three months? (Falling includes landing on the ground or at some other level, such as a chair or bed.)

❑ Yes ❑ No

If you have fallen in the past three months:

How many times have you fallen? _____

Did any of these falls result in an injury that required medical attention?

❑ Yes ❑ No

Do you have a fear of falling?

❑ Yes ❑ No

Do you restrict your activities because you are afraid you might fall?

❑ Yes ❑ No