

# Fit and Strong! Participant Post-Survey

**Participant Number or Name:** \_\_\_\_\_

**Workshop ID:** \_\_\_\_\_ **Site Name:** \_\_\_\_\_

**Start date of program:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (e.g., 05/01/23)

**Program Name:**  
 Fit and Strong!

1. Since this program began, I have applied the skills I learned in this program to: **Check all that apply.**

<input type="checkbox"/>	Manage emotions like stress, depression, anger, fear, or frustration
<input type="checkbox"/>	Manage pain, fatigue, or other symptoms of my chronic condition(s)
<input type="checkbox"/>	Increase my strength, flexibility, endurance, or overall physical fitness
<input type="checkbox"/>	Make a medication list that includes all current medications, dosages, and dates started
<input type="checkbox"/>	Solve a problem or issue I was experiencing in my life
<input type="checkbox"/>	Help someone else use a technique I learned in this program

2. How likely is it that you would recommend this program to a friend or family member?

Not at all likely      0   1   2   3   4   5   6   7   8   9   10      Extremely likely

3. Would you be willing to share your story to help other people gain access to these programs?

Yes    No

4. What was most valuable to you in this program?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Please provide any thoughts or feedback about the program leader(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# IDPH Post-Survey

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Hello. Thank you for your participation in the Fit & Strong! program. As a class participant we are asking you to fill out this brief survey that will ask you questions about your general health and exercise habits. We ask you to complete this survey at the start and end of your Fit & Strong! class. This information is used to assess the impact the Fit & Strong! program is having on its participants.

Your name will NOT be attached to your survey, instead an anonymous ID will be used (e.g., Participant 01).

Your participation is voluntary. You may skip any questions you do not wish to answer.

If you have any questions about this survey, please ask your Fit & Strong! class instructor

Thank you!

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1) Your Name/Identifier

(Note: Names will not be sent to the Fit & Strong! project team, only anonymous identifiers, like Participant 01).

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2) Today's Date

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3) Name of Organization Hosting this Class:

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4) Name of Instructor(s) Leading this Class:

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Please complete the questions below that asks about FALLS. You can skip any questions you do not feel comfortable answering.

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In the past 3 months, have you fallen?

- No
- Yes

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How many times?

\_\_\_\_\_

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If you fell in the last 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)

\_\_\_\_\_

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How fearful are you of falling?

- Not at All
- A Little
- Somewhat
- A Lot

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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?

- Extremely
- Quite a Bit
- Moderately
- Slightly
- Not at All

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I have made safety modifications in my home, such as installing grab bars or securing loose rugs to reduce my risk of falling.

- True
- False

Please complete the survey below that asks about how often you feel the way described below. You can skip any questions that you do not feel comfortable answering.

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39) How often do you feel a lack of companionship?  Hardly ever/never  
 Some of the time  
 Often

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40) How often do you feel left out?  Hardly ever/never  
 Some of the time  
 Often

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41) How often do you feel isolated from others?  Hardly ever/never  
 Some of the time  
 Often

Please complete the survey below that asks about how often you feel the way described below. You can skip any questions that you do not feel comfortable answering.

### During the past 7 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
42) I feel fatigued	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43) I have trouble starting things because I am tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44) How run-down did you feel on average?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45) How fatigued were you on average?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### In the past 7 days...

	Very poor	Poor	Fair	Good	Very good
46) My sleep quality was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### In the past 7 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
47) My sleep was refreshing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
48) I had a problem with my sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
49) I had difficulty falling asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### Ability to Participate in Social Roles and Activities

	Never	Rarely	Sometimes	Usually	Always
50) I have trouble doing all of my regular leisure activities with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
51) I have trouble doing all of the family activities that I want to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
52) I have trouble doing all of my usual work (include work at home)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
53) I have trouble doing all of the activities with friends that I want to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please complete the survey below that ask about your use of HEALTHCARE SERVICES. You can skip any questions that you do not feel comfortable answering.

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Have you ever had a total joint replacement?  Yes  
 No

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Check all total joint replacement surgeries you've had.  Right Hip  
 Right Knee  
 Left Hip  
 Left Knee  
 Other

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If Other, please specify. \_\_\_\_\_

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Please list the date of the joint replacement/s (month and year) \_\_\_\_\_

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Are you considering having joint replacement surgery at this time?  Yes  
 No

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On a scale from 1-10, how strongly do you feel that you will need HIP surgery in the next year? 1 being not strongly and 10 being very strongly.  1  2  3  4  
 5  6  7  8  
 9  10

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On a scale from 1-10, how strongly do you feel that you will need KNEE surgery in the next year? 1 being not strongly and 10 being very strongly.  1  2  3  4  
 5  6  7  8  
 9  10

Please complete the survey below that asks about PAIN, STIFFNESS, AND FUNCTION OF YOUR KNEES AND HIPS. Select one number only for each question.

**The following questions concern the amount of PAIN you are currently experiencing in your hips and/or knees. For each situation, please indicate the amount of pain you recently experienced using the following scale: None, Mild, Moderate, Severe, Extreme.**

**QUESTION: How much PAIN do you have?**

	None	Mild	Moderate	Severe	Extreme
61) Walking on a flat surface	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
62) Going up or down stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
63) At night while in bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
64) Sitting or lying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
65) Standing upright	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**The following questions concern the amount of joint STIFFNESS (not pain) you are currently experiencing in your hips and/or knees. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints. Select one number only for each question.**

	None	Mild	Moderate	Severe	Extreme
66) How severe is your stiffness after first waking in the morning?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
67) How severe is your stiffness after sitting, lying, or resting later in the day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**The following questions concern your PHYSICAL FUNCTION. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you are currently experiencing due to arthritis in your hips and/or knees. Select one number only for each question.**

**QUESTION: What degree of difficulty do you have with...**

	None	Mild	Moderate	Severe	Extreme
68) Descending (walking DOWN) stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
69) Ascending (walking UP) stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
70) Rising from sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
71) Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
72) Bending to the floor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
73) Walking on a flat surface	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
74) Getting in/ out of a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
75)					

Going shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
76) Putting on socks/ stockings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
77) Rising from bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
78) Taking off socks/ stockings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
79) Lying in bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
80) Getting in/ out of the bathtub	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
81) Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82) Getting on/ off of the toilet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
83) Heavy domestic duties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
84) Light domestic duties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Please complete the survey below that asks about your current LEVEL OF PHYSICAL ACTIVITY.

Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation.

The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

Examples of Activities:

<p><b>Light activities</b></p> <ul style="list-style-type: none"> <li>• your heart beats slightly faster than normal</li> <li>• you can talk and sing</li> </ul>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Walking Leisurely</p> </div> <div style="text-align: center;">  <p>Stretching</p> </div> <div style="text-align: center;">  <p>Vacuuming or Light Yard Work</p> </div> </div>
<p><b>Moderate activities</b></p> <ul style="list-style-type: none"> <li>• your heart beats faster than normal</li> <li>• you can talk but not sing</li> </ul>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Fast Walking</p> </div> <div style="text-align: center;">  <p>Aerobics Class</p> </div> <div style="text-align: center;">  <p>Strength Training</p> </div> <div style="text-align: center;">  <p>Swimming Gently</p> </div> </div>
<p><b>Vigorous activities</b></p> <ul style="list-style-type: none"> <li>• your heart rate increases a lot</li> <li>• you can't talk or your talking is broken up by large breaths</li> </ul>	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Stair Machine</p> </div> <div style="text-align: center;">  <p>Jogging or Running</p> </div> <div style="text-align: center;">  <p>Tennis, Racquetball, Pickleball or Badminton</p> </div> </div>

89) I rarely or never do physical activity.

- Yes  
 No

- 
- 90) I do some LIGHT or MODERATE physical activities, but not every week.  Yes  
 No
- 
- 91) I do some LIGHT physical activity every week.  Yes  
 No
- 
- 92) I do MODERATE physical activity every week, but less than 30 minutes a day or 5 days a week.  Yes  
 No
- 
- 93) I do VIGOROUS physical activity every week, but less than 20 minutes, 3 or more days per week.  Yes  
 No
- 
- 94) I do 30 minutes or more per day of MODERATE physical activities, 5 or more days a week  Yes  
 No
- 
- 95) I do 20 minutes or more a day of VIGOROUS physical activities, 3 or more days a week  Yes  
 No
- 
- 96) I do activities to increase muscle STRENGTH, such as lifting weights or calisthenics, once a week or more.  Yes  
 No
- 
- 97) I do activities to increase FLEXIBILITY, such as stretching or yoga, once a week or more.  Yes  
 No
- 
- 98) Sometimes I feel unsteady when I am walking.  Yes  
 No
- 
- 99) I steady myself by holding onto furniture when walking at home.  Yes  
 No

Please complete the survey below.

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100) In general, would you say that your health is

- Excellent
- Very Good
- Good
- Fair
- Poor

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101) What is your weight in pounds?

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102) On a scale from 1-10, how sure are you that you can manage your condition so that you can do the things you need and want to do with 1 being totally unsure and 10 being totally sure?

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

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103) How often do you feel lonely?

- Always
- Often
- Sometimes
- Rarely
- Never

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104) How often do you feel isolated from those around you?

- Always
- Often
- Sometimes
- Rarely
- Never

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105) Since this program began, what have you done to manage your chronic condition(s)? Select all that apply.

- Talked to a family member or friend about my health
- Talked to a healthcare provider about how I can better manage my chronic condition
- Had my medication reviewed by a pharmacist or healthcare provider
- Started or continued to exercise
- Made changes to how I choose the food I eat
- Participate in or plan to participate in another health-related or exercise program in my community

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106) How would you rate your overall satisfaction with the quality of the program?

- Very Dissatisfied
- Dissatisfied
- Okay
- Satisfied
- Very Satisfied

# Attendance Record

Please complete the attendance record for this participant. Check the box for each class session that the participant attended. Leave boxes unchecked if the participant did not attend that session.

Thank you!

**Attendance Record. Please check the boxes for each class this participant attended. Leave boxes blank for any classes this participant did not attend.**

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
107) Classes Attended (Select all that apply)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>