[redacted]

Centre number: ☐☐

Trial ID number: ☐☐☐☐☐

BACKGROUND INFORMATION

Please answer the following questions:

1. What is your date of birth? ☐☐ / ☐☐ / 1 9 ☐☐
   Day / *Month* / *Year*

2. Are you? Male ☐ Female ☐

3a. Have you fallen in the last 12 months? Yes ☐ No ☐
   (Please cross one box only)

3b. If 'Yes', how many times have you fallen? ☐☐

4a. Have you fallen in the last 24 months? Yes ☐ No ☐
   (Please cross one box only)

4b. If 'Yes', did any of the falls in the last 24 months require hospital attention? Yes ☐ No ☐

5. Can you walk for 10 yards without the use of a zimmer frame, walker or wheelchair? Yes ☐ No ☐

6. Have you had any lower limb surgery in the last three months? Yes ☐ No ☐

7. Do you have any lower limb surgery planned in the next six months? Yes ☐ No ☐

8. Have you had any toe or lower limb amputations (e.g. toes removed)? Yes ☐ No ☐

9a. Do you currently require modifications to your shoes in order to wear them? Yes ☐ No ☐

9b. If 'Yes', what modifications are made to your shoes?

   (Please specify) _____

10. Are you currently wearing an insole or orthotic in your shoe (either one you have bought over the counter or one given to you by a podiatrist)? Yes ☐ No ☐

11. Do you experience any of the following health problems?
(Please cross all that apply)

ALS / Lou Gehrig's disease ☐
Alzheimer's disease ☐
Arthritis ☐
Dementia ☐
Depression ☐
Diabetes ☐
Dizziness / Vertigo ☐
Huntington's ☐
Meniere's disease / conditions affecting balance ☐
Multiple sclerosis ☐
Numbness or tingling in your feet or lower limbs ☐
Osteoporosis ☐
Parkinson's ☐

12. Have you broken any bones in the past 12 months? Yes ☐ No ☐

13. If 'Yes', which bone(s) did you break?

Bone 1: _____

Bone 2: _____

Bone 3: _____

14. During the past 4 weeks have you worried about having a fall?
(Please cross one box only)

All of the time ☐
Most of the time ☐
A good bit of the time ☐
Some of the time ☐
A little of the time ☐
None of the time ☐

15. To which of these ethnic groups do you belong?
(Please cross one box only)

White ☐
Asian or Asian British ☐
Black or Black British ☐

Other ethnic group ☐ If 'Other', Please describe: _____

Centre number: | | |

Trial ID number: | | | | | |

Please enter the date you are completing this form: | | | / | | | / | 2 | 0 | | |

Day *Month* *Year*

CONTACT SHEET

If you would like to take part in the REFORM trial please can you tell us your:

Title:

Forename:

Surname

Address

Post code

Telephone number:

Your mobile number:

Your email address:

GP name:

GP Address

If you do not wish to take part you do not need to complete your contact details

Thank you for taking the time to complete these questions.
Please return these forms in the pre-paid envelope provided to the York Trials Unit.

Admin code: | | | 1784096656