CONFIDENTIAL

REFORM Study

Reducing falls with ORthosis and a Multifaceted podiatry intervention

Participant Baseline Questionnaire

For office use only

Centre number: ☐☐

Participant's trial ID number: ☐☐☐☐☐

Date questionnaire sent: ☐☐ / ☐☐ / 2 0 ☐☐

Day *Month* *Year*

[redacted]

[redacted]

PLEASE READ ALL THE INSTRUCTIONS BEFORE COMPLETING THE QUESTIONNAIRE

Thank you for agreeing to take part in this study. The responses you give in this questionnaire will help us find out the best way to stop people who are over 65 years old from having a fall.

Please answer ALL the questions. Although some of the questions may not seem relevant to yourself or may appear similar, they do give us valuable information.

If you find it difficult to answer the question, please give the best answer you can.

Please follow the instructions for each section carefully.

For each section, if you are asked to put a cross in the box, please use a cross rather than a tick, as if you were filling out a ballot paper.

For example in the following question, if your answer to the question is 'yes', you should place a cross firmly in the box next to yes.

Do you drive a car? Yes ☒

No ☐

If you are asked to write your answer, please do so by entering your answer in the box provided, for example:

How old are you? | 7 | 5 | years

Please use a black or blue pen for all the questions.

Please do not use a pencil or any other coloured pen.

If you have any queries or problems completing this questionnaire please contact the trial co-ordinator, Sarah Cockayne, telephone number XXXX, email XXXX.

SECTION 1

This section asks about any falls you have had in the **past 6 months** and about some general information about you.

Please enter the date you are completing this questionnaire:

☐☐ / ☐☐ / 2 0 ☐☐

Day *Month* *Year*

1. Have you fallen in the **past 6 months**?
(Please cross one box only)

☐ Yes ☐ No ☐ Don't know

1a. If 'Yes', how many falls did you have in the **past 6 months**? ☐☐

2. 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
☐	☐	☐	☐	☐	☐

3a. Please tell us your height ☐ feet ☐☐ inches **or** ☐☐☐ cm

3b. Please tell us your weight ☐☐ stone ☐☐ lbs **or** ☐☐☐.☐ kgs

4. Are you taking more than four medications prescribed by a doctor?
(Please cross one box only)

☐ Yes ☐ No

5. Have you been referred to a falls clinic / falls service?
(Please cross one box only)

☐ Yes ☐ No

SECTION 2

This section asks about your health in general.

By placing a cross in one box in each group below, please indicate which statements best decribes your own health **today**.

Mobility

I have no problems in walking about ❑

I have some problems in walking about ❑

I am confined to bed ❑

Self-Care

I have no problems with self-care ❑

I have some problems washing or dressing myself ❑

I am unable to wash or dress myself ❑

Usual Activities *(e.g. work, study, housework, family or leisure activities)*

I have no problems with performing my usual activities ❑

I have some problems with performing my usual activities ❑

I am unable to perform my usual activities ❑

Pain / Discomfort

I have no pain or discomfort ❑

I have moderate pain or discomfort ❑

I have extreme pain or discomfort ❑

Anxiety / Depression

I am not anxious or depressed ❑

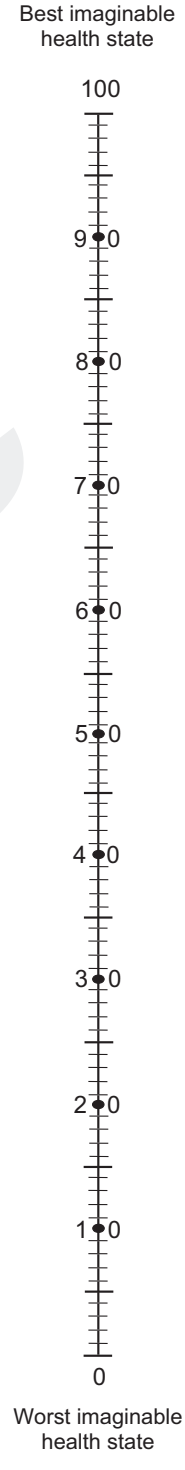
I am moderately anxious or depressed ❑

I am extremely anxious or depressed ❑

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your health state is today.

Your own health state today



SECTION 3

Now we would like to ask some questions about how concerned you are about the possibility of falling.

Please reply thinking how you usually do the activity. If you currently do not do the activity, please answer to show whether you think you would be concerned about falling IF you did the activity.

For each of the following activities, please cross the box which is closest to you own opinion to show how concerned you are that you might fall if you did the activity.

	Not at all concerned	Somewhat concerned	Fairly concerned	Very concerned
Getting dressed or undressed	☐	☐	☐	☐
Taking a bath or shower	☐	☐	☐	☐
Getting in or out of a chair	☐	☐	☐	☐
Reaching for something above your head or on the ground	☐	☐	☐	☐
Walking up or down a slope	☐	☐	☐	☐
Going out to a social event (eg, religious service, family gathering or club meeting)	☐	☐	☐	☐

SECTION 4

This section asks about how you've been feeling. Answer each question by placing a cross in the box that best describes your answer.

1a. I tend to bounce back after illness or hardship

Not true at all	Rarely true	Sometimes true	Often true	True nearly all of the time
☐	☐	☐	☐	☐

1b. I am able to adapt to change

Not true at all	Rarely true	Sometimes true	Often true	True nearly all of the time
☐	☐	☐	☐	☐

SECTION 5

We are interested in finding out how often you carry out some activities. Please cross one box for each question.

1. **In the last 3 months**, how often have you carried out these activities?

	Never	Less than once per week	1 or 2 times a week	Most days
Preparing main meals	☐	☐	☐	☐
Washing up	☐	☐	☐	☐

2. **Over the last 3 months**, how often have you carried out the following?

	Never	1-2 times in 3 months	3-12 times in 3 months	At least weekly
Washing clothes	☐	☐	☐	☐
Light housework	☐	☐	☐	☐
Heavy housework	☐	☐	☐	☐
Local shopping	☐	☐	☐	☐
Social outings	☐	☐	☐	☐
Walking outside for over 15 minutes	☐	☐	☐	☐
Actively pursuing a hobby	☐	☐	☐	☐
Driving a car/travel on a bus	☐	☐	☐	☐

3. In the **last 6 months**, how often have you undertaken:

	Never	1-2 times in 6 months	3-12 times in 6 months	At least weekly
Travel outing / car ride	☐	☐	☐	☐

	Never	Light	Moderate	Heavy / All necessary
Gardening	☐	☐	☐	☐
Household maintenance	☐	☐	☐	☐

In the **last 6 months**, how often have you undertaken:

	None	1 in 6 months	Less than 1 in 2 weeks	More than 1 every 2 weeks
Reading books	☐	☐	☐	☐

	None	Up to 10 hours/week	10 - 30 hours/week	Over 30 hours/week
Gainful work	☐	☐	☐	☐

SECTION 6

This section is about visits you have had to a NHS hospital as a patient **for any reason**.

Answer each question by placing a cross in the box that best describes your answer.

Attending hospital

1a. During the **last six months** have you stayed overnight in an NHS hospital?

☐ Yes ☐ No (go to section 7)

1b. If 'Yes', on how many separate occasions did you stay overnight in hospital? ☐☐

1c. For each stay please complete the information below:

	Number of nights in hospital	Reason for admittance
e.g.	3	ANGINA

SECTION 7

This section is about other services you have used in the **past six months** as a patient **for any reason**. If the health care you received was related to a fall, record this in the 'about a fall' column. If the health care was for any other reason, enter this in the 'other reason' column.

Please fill in all of the boxes even if you have not had any visits. This information is really important for us.

	About a fall	Other reason
For example, if you have not used a service for any reason then put a '0' in both boxes:	0 0	0 0
If you have used a service three times about a fall and once for another reason then you would write:	0 3	0 1

1. Over the **past six months,** how many times have you:

Other visits to NHS hospital	About a fall *(If None enter '00')*	Other reason *(If None enter '00')*
a. Visited hospital for an out-patient appointment?		
b. Visited hospital for a day case / procedure (not overnight)?		
c. Attended Accident and Emergency?		

Other care from the NHS	About a fall *(If None enter '00')*	Other reason *(If None enter '00')*
d. Seen your GP at the surgery or at home?		
e. Seen a nurse at your GP practice or the district or community nurse?		
f. Seen an occupational therapist and/or physiotherapist at home?		

Transportation	About a fall *(If None enter '00')*	Other reason *(If None enter '00')*
g. Used a '999' emergency ambulance?		
h. Used the Patient Transport Service?		

Support services

2a. Have you received any help or care (e.g. dressing, tasks around the home, providing meals, shopping from a relative or a friend) in the **last 6 months**?
(Please cross one box only)

☐ Yes ☐ No (go to 3a)

2b. If 'Yes', thinking about the **last 6 months**, typically how many hours per week did someone help you?

☐☐☐

3a. Does a paid care worker visit you at home?
(Please cross one box only)

☐ Yes ☐ No (go to 4a)

3b. If 'Yes', thinking about the **last 6 months**, typically how many days per week did a care worker visit?

☐

4a. Do you use meals on wheels?
(Please cross one box only)

☐ Yes ☐ No

4b. If 'Yes', thinking about the **last 6 months**, typically how many times a week did you use meals on wheels?

☐☐

SECTION 8

This section asks about any extra costs you have had in the **past six months**.

1a. In the **last 6 months**, have you had to buy any new equipment (e.g. a bed), or paid to have any changes made to your house (e.g. installed a stairlift) due to ill health?
(Please cross one box only)

☐ Yes ☐ No (go to section 9)

1b. If 'Yes', please tell us the item and how much it cost.
(Please enter the cost to the nearest pound)

Item bought	Cost
	£
	£
	£

SECTION 9

This section asks about your living arrangements and some general information about you.

1. Do you?
(Please cross all that apply)

Live alone ☐

Live with a partner or spouse? ☐

Live with a friend or relative? ☐

Live in sheltered accommodation? ☐

2a. Did your education continue after the minimum school leaving age? ☐ Yes ☐ No

2b. Do you have a degree or equivalent professional qualification? ☐ Yes ☐ No

SECTION 10

This section asks about your mood. Choose the best answer for how you have felt this past week by placing a cross in the appropriate box.

		Yes	No
1.	Are you basically satisfied with your life?	☐	☐
2.	Have you dropped many of your activities and interests?	☐	☐
3.	Do you feel that your life is empty?	☐	☐
4.	Do you often get bored?	☐	☐
5.	Are you in good spirits most of the time?	☐	☐
6.	Are you afraid that something bad is going to happen to you?	☐	☐
7.	Do you feel happy most of the time?	☐	☐
8.	Do you often feel helpless?	☐	☐
9.	Do you prefer to stay at home, rather than going out and doing new things?	☐	☐
10.	Do you feel you have more problems with memory than most?	☐	☐
11.	Do you think it is wonderful to be alive now?	☐	☐
12.	Do you feel pretty worthless the way you are now?	☐	☐
13.	Do you feel full of energy?	☐	☐
14.	Do you feel that your situation is hopeless?	☐	☐
15.	Do you think that most people are better off than you are?	☐	☐

For office use only: Insert total score ☐☐

Thank you for taking the time to complete this questionnaire. Please return it to the York Trials Unit at the University of York in the pre-paid envelope provided.