Three Month Booster Evaluation

Stepping On

Workshop Site: _____ Today's Date: _____

1. Have you experienced a fall since the completion of the workshop?
   ___No
   ___Yes
   If yes, what was the cause of the fall? _____

2. **Since** the workshop, have you taken the following actions? Place an X by the appropriate response.

	Yes	No
Had a regular eye exam?		
Have talked with a vision expert about improving your vision?		
Practiced exercises routinely?		
Assessed your home environment for safety hazards?		
Made adaptations or problem-solved ways to reduce home hazards?		
Considered safe features when choosing footwear?		
Practiced techniques for safe transfers, standing, walking, climbing curbs & stairs?		
Used ways of finding out the side effects of medications, such as talking with your pharmacist or doctor?		
Have calculated (or know how to determine) intake of Vitamin D and calcium and made adjustment, if needed?		

Additional Questions on Back

3. Overall, to what extent did this program help you to reduce your risk of falls? Please circle the one best response.

   Not at all Slightly Some Very much Absolutely

4. List the three most important things you remember since the workshop:

   a.

   b.

   c.

5. Would you be interested in serving as a peer leader?

6. Any other comments you would like to make.