BINGOcize® ASSESSMENT DECISION TREE

START HERE: Does my participant need to complete paper/pencil pre/post assessments?

Is this a first time Bingocizer?

Yes

Bingocizer must complete Bingocize Pre/Post Assessments

No

Has it been more than **90** days since the Bingocizer completed their last 10-week Bingocize workshop?

Yes

Bingocizer must complete Bingocize Pre/Post Assessments

No

Is the Bingocizer participating in a DIFFERENT 10-week workshop (exercise-only, nutrition, or falls prevention)?

Yes

Bingocizer must complete Bingocize Pre/Post Assessments for the new 10-week workshop.

No

Bingocizer does NOT need to complete paper/pencil Pre/Post Assessments*

Available in 2023, If Bingocizer is playing via Bingocize Online Pre/Post Assessments are built into the workshop

Participant Pre-Unit Information Form

Today's date:_____/_____/_____
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Participant I.D._____/_____/_____(first two letters of your first name, first two letters of your last name, last two numbers of your birth year)

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1. Which Bingocize® session are you participating in? (circle one)
◯Exercise-Only ◯Falls-Prevention ◯Nutrition Other_____

2. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?
◯Yes ◯No

3. How old are you today?_____years

4. Do you live alone? ◯Yes ◯No

5. Are you: ◯Male or ◯Female?

6. Are you of Hispanic, Latino, or Spanish origin? ◯Yes ◯No

7. What is your race? **Check all that apply**.

◯American Indian or Alaska Native
◯Asian
◯ White
◯Black or African American
◯Native Hawaiian or other Pacific Islander

8. What is the highest grade or level of school that you have completed?
◯Less than high school
◯Some high school
◯High school graduate or GED
◯Some college or vocational school
◯College graduate or higher

9. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)? **Check Yes or No**.

Arthritis or other bone/joint disease	◯Yes ◯No	High blood pressure/hypertension	◯Yes ◯No
Breathing/lung disease	◯Yes ◯No	Glaucoma/other chronic eye problem	◯Yes ◯No
Cancer	◯Yes ◯No	Osteoporosis	◯Yes ◯No
Depression	◯Yes ◯No	Parkinson's Disease	◯Yes ◯No
Diabetes	◯Yes ◯No	Other Chronic Condition(s) (specify):	_____ _____
Heart disease or blood circulation problem	◯Yes ◯No		

10. Are you limited in any way in any activities because of physical, mental, or emotional problems? ◯ Yes ◯ No

11. In general, would you say that your health is:

◯ Excellent ◯ Very good ◯ Good ◯ Fair ◯ Poor

12. Over the last two weeks, how much have you been bothered by the feelings below

	0 Not at all	1	2	3 A little	4	5	6	7	8	9 Severely
a. Feeling sad, down, or uninterested in life	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
b. Not having the social support you feel you need	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

13. In the past 3 months, how many times have you fallen? ☐ none OR ____ times

If you fell in the past 3 months:

a. How many of these falls caused an injury? *(By an injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor.)*

_____ number of falls causing an injury

b. Where did the fall(s) occur***?*** (*Please check all that apply)*

◯ Indoors ◯ Outdoors ◯ Both indoors and outdoors

c. What happened after you fell and had an injury? *(Please check all that apply)*

◯ Went to the Emergency Room ◯ Was admitted to the hospital
◯ Visited my Primary Care Physician ◯ Did not seek medical care _____

14. How fearful are you of falling?

◯ Not at all ◯ A little ◯ Somewhat ◯ A lot

15. Please mark the circle that tells us how sure you are that you can do the following activities.

How sure are you that:

	Very Sure	Sure	Somewhat sure	Not at all sure
a. I can find a way to get up if I fall	◯	◯	◯	◯
b. I can find a way to reduce falls	◯	◯	◯	◯
c. I can protect myself if I fall	◯	◯	◯	◯
d. I can increase my physical strength	◯	◯	◯	◯
e. I can become more steady on my feet	◯	◯	◯	◯

16. 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

17. 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

18. What best describes your activity level?

◯ Vigorously active for at least 30 min, 3 times per week
◯ Moderately active at least 3 times per week
◯ Seldomly active, preferring sedentary activities

19. Please indicate which type of insurance you have:

◯ Medicaid/Medi-cal ◯ Veterans Health
◯ Medicare ◯ No insurance
◯ Tricare ◯ Private insurance not listed above: _____