wiha Wisconsin Institute for Healthy Aging

Lindsborg Community Hospital
Salina Regional Health Center
Partners caring for the health of the Smoky Valley communities.

Registration Form
Stepping On Workshop
Tuesdays, March 13 - April 24, 2018
9:30 am-11:30 am

Your Name: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ (HOME) _____ (CELL)

Do you use e-mail: ___YES ___NO

If YES, what is your e-mail address? _____

Please circle answers:

1. Do you live in a house or apartment? YES NO
   Note: If your answer is NO, this workshop may not be appropriate for you. Consider talking with your doctor about having a Falls Assessment and other methods of preventing falls.

2. Are you able to walk without the help of another person? YES NO
   Note: If your answer is NO, this workshop may not be appropriate for you. Consider talking with your doctor about having a Falls Assessment and other methods of preventing falls.

3. Do you use a walker, scooter or wheelchair most of the time indoors? YES NO
   Note: If you need assistance with a walker, scooter or wheelchair most of the time when walking indoors, this workshop may not be appropriate for you. Consider talking with your doctor about having a Falls Assessment and other methods of preventing falls.

4. Have you fallen in the past year? YES NO
   If yes, how many times? _____
   Note: If you have fallen six or more times in the past year, consider talking with your doctor about whether you may benefit from additional individualized assessment or intervention.

5. Do you have any problems with your vision? YES NO
   If YES: please describe what we'd need to do to accommodate your needs in the workshop:

   _____

6. Do you have any problems with your hearing? YES NO

If YES: please describe what we'd need to do to accommodate your needs in the workshop

_____

7. How did you hear about the *Stepping On* workshop?

__ friend ___ health care provider __brochure (where picked up?)_____

___family member __ internet __other (please specify)_____

8. Will you need transportation assistance in getting to the workshop? YES NO

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

Please mail form to:
Lindsborg Community Hospital
ATTN: Cynthia Woodard
605 W. Lincoln
Lindsborg, KS 67456

CONSENT TO USE IMAGE FOR QUALITY ASSURANCE, EDUCATIONAL OR PROMOTIONAL PURPOSES

By checking the box below, I voluntarily consent to and authorize all persons associated with the Wisconsin Institute for Healthy Aging (WIHA) and Lindsborg Community Hospital (LCH) to videotape or otherwise photograph or record my voice or image in this workshop for quality assurance, promotional or educational purposes only, including use in training manuals and on websites and brochures. Neither my name, nor any other identifying information will be provided unless I provide specific separate consent. I waive any right to inspect or approve the videotape or any of the other photography or recordings or to receive any compensation for my participation.

☐ Yes
☐ No

_____
Signature