

Stepping On In-Person Workshop Registration Form

May 28 to July 9 , Thursdays 1-3 pm
Bethesda Lutheran Church, 109 S. 6 , Bayfield

Name: _____

Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (HOME) _____ (CELL) _____

Email address (if you use): _____

Emergency contact name and phone number:

Please circle answers:

1. Do you live in a house or apartment?

(Note: If your answer to any of the following questions is NO this workshop may not be appropriate for you. Consider talking with your provider about having a falls assessment and other methods of preventing falls.)

YES

NO

2. Are you able to walk without the help of another person?

(Note: If your answer to any of the following questions is NO this workshop may not be appropriate for you. Consider talking with your provider about having a falls assessment and other methods of preventing falls.)

YES

NO

3. Do you use a walker, scooter, or wheelchair most of the time indoors?

(Note: If your answer to any of the following questions is NO this workshop may not be appropriate for you. Consider talking with your provider about having a falls assessment and other methods of preventing falls.)

YES

NO

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 provider about whether you may benefit from additional individualized assessment or intervention.

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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.

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.

7. Has a Physical Therapist placed any restrictions or limitations on you in the past year?

YES

NO

If YES: please share what your limits are to help assess your safety.

8. Can you attend all of the sessions?

YES

NO

Note: If you will miss more than 1 or 2 sessions, we suggest that you attend a workshop for a time when you would be available to attend at least 5 of the 7 sessions.

9. How did you hear about the [Stepping On](#) workshop?

friend

health care provider

brochure (from where?) _____

family member

other (please specify) _____

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

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

By checking yes below, I voluntarily consent to and authorize all persons associated with the Wisconsin Institute for Healthy Aging (WIHA) to videotape, photograph or record my voice or image in this workshop for quality assurance, promotional or educational purposes, 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