Stepping On Workshop Registration Form

Seven Week Course

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/check 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 _____ other (please specify) _____

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Please mail or email form to:

Newman Regional Health
ATTN: Alexa Parks, Stepping On Coordinator
1201 West 12th Avenue
Emporia, KS 66801

aparks@newmanrh.org

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 Newman Regional Health and its affiliates 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