

# 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: Anna Blanton, Stepping On Coordinator  
1201 West 12<sup>th</sup> Avenue  
Emporia, KS 66801

[ablanton@newmanrh.org](mailto:ablanton@newmanrh.org)

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**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