Name: __________________________________________

Today’s Date: __________________________________

**MOOD, ENERGY LEVEL AND MENTAL HEALTH**
For the following questions, please answer by putting a check in the box that most applies to you:

<table>
<thead>
<tr>
<th></th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
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</thead>
<tbody>
<tr>
<td>1. I feel younger than my age</td>
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<tr>
<td>2. I feel independent</td>
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<td>3. I feel energetic</td>
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<td>4. I live an active life</td>
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<td>5. I feel strong</td>
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<td>6. I feel healthy</td>
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<td>7. I am as active as other people my age</td>
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**MOBILITY & DAILY LIVING ACTIVITIES**
For the following questions, please answer by putting a check in the box that most applies to you:

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<tr>
<th></th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
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</thead>
<tbody>
<tr>
<td>1. I find it easy to walk up or down two or more flights of stairs</td>
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<td>2. I have no trouble taking the trash out</td>
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<td>3. I do housework such as vacuuming and dusting on my own without difficulty</td>
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<td>4. I can easily lift a gallon of milk (8lbs)</td>
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<td>5. I have no trouble reaching into high cupboards or reaching down to pick up something on the floor</td>
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<tr>
<td>6. I do not have trouble doing outdoor work such as mowing the lawn, raking leaves, or gardening</td>
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<td>7. I can easily walk a mile</td>
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</tbody>
</table>

-Updated: January 2015-
8. How many times have you fallen within the past year?
   ____ 0
   ____ 1-3
   ____ 4-6
   ____ 7-9
   ____ 10+

9. Are you worried about falling?
   ____ No
   ____ A Little
   ____ Moderately
   ____ Very
   ____ Extremely

10. How much “bodily pain” have you generally had during the past four weeks?
    (While doing normal activities of daily living)
    ____ None
    ____ Very Little
    ____ Moderate
    ____ Quite A Bit
    ____ Severe

11. In general, how would you rate the quality of your life?
    ____ Poor
    ____ Adequate
    ____ Good
    ____ Very Good
    ____ Exceptional

12. In general, do you currently require household or nursing assistance to carry out daily activities?
    ____ Yes   ____ No
    
    If yes, please check the reason(s):
    ____ Health problems
    ____ Chronic Pain
    ____ Lack of Strength or Endurance
    ____ Lack of Flexibility
    ____ Other Reasons: ______________________________________________

13. In a typical week, how often do you leave your house?
    (To run errands, go to work, go to meetings, classes, church, social functions, etc.)
    ____ Less than once a week
    ____ 1-2 times a week
    ____ 3-4 times a week
    ____ Most every day

-Updated: January 2015-
14. Do you currently participate in regular physical exercise (such as walking, sports, exercise class, house work or yard work) that is strenuous enough to cause a noticeable increase in breathing, heart rate, or perspiration? ___Yes ___No

If yes, how many days per week? ______________

HEALTH INDICATORS
15. Have you had a Bone Density (BMD) test in the last year?
   ___ Yes
   ___ No

   If yes, did your doctor state your results were:
   ___ Normal
   ___ Osteoporosis
   ___ Osteopenia

16. Do you currently take medicine for osteoporosis/osteopenia?
   ___ Yes
   ___ No

   If Yes, what: ________________________________________________________

17. Has your doctor told you that you are diabetic?
   ___ Yes
   ___ No
   ___ Don’t Know

18. Has your doctor told you that you are pre-diabetic?
   ___ Yes
   ___ No
   ___ Don’t Know

19. Do you currently take medicine for diabetes?
   ___ Yes
   ___ No

-Updated: January 2015-
## GROWING STRONGER CLASS EVALUATION

For the following questions, please answer by putting a check in the box that most applies to you:

<table>
<thead>
<tr>
<th>Question</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Usually</th>
<th>Always</th>
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<tbody>
<tr>
<td>1. Overall, are you satisfied with the class?</td>
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<td>2. Is the facility safe, clean, and comfortable?</td>
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<td>3. Do you feel that your health is better because of the program?</td>
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<td>4. Do you feel physically stronger?</td>
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<td>5. Do you have more energy?</td>
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<td>6. Do you sleep better?</td>
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<td>7. Are your joints any less painful?</td>
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<td>8. Have you become more active?</td>
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<tr>
<td>9. Growing Stronger Site:</td>
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<tr>
<td>10. What prompted you to enroll in the class?</td>
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<td>11. How did you hear about the class?</td>
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<tr>
<td>12. Which exercises do you like best about Growing Stronger?</td>
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<tr>
<td>13. Which exercises do you like least about the Growing Stronger?</td>
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<tr>
<td>14. Additional Comments are welcome:</td>
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</table>

9. Growing Stronger Site: _______________________________________________

10. What prompted you to enroll in the class? ____________________________

11. How did you hear about the class? ____________________________________

12. Which exercises do you like best about Growing Stronger? ______________

13. Which exercises do you like least about the Growing Stronger? _________

14. Additional Comments are welcome: ____________________________________

-Updated: January 2015-