**Stepping On Registration Form**

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| Date: / / | Form completed by: | Not interested/Declined  Data entered  Info Pack Sent |
| First name: Surname  Address: Postcode:  Home phone: Mobile:  Date of birth: Gender: Male/Female  Are you of Aboriginal or Torres Strait Islander origin? (Please circle) Yes No  Are you a carer? (Please circle) Yes No  Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  IT Capacity Yes No Comment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **How did you find out about the program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| 1. **Falls History**    1. Have you had a fall in the last year?  Yes  No (Excluded if ‘No’ to both Q1.1 and Q1.2)    2. Are you concerned about falling?  Yes  No (Excluded if ‘No’ to both Q1.1 and Q1.2) | | |
| 1. **Mobility Status**    1. Can you walk independently (without assistance of another person)  Yes  No (Excluded)    2. Do you use a walking frame  Yes (Go to Q 2.3)  No (Skip to Q3)    3. Can you walk safely inside your house without using a walking frame  Yes  No (Excluded) | | |
| 1. **Cognitive Impairment**    1. Do you have a condition that affects your memory (Dementia, Parkinson’s, stroke)  Yes (Go to Q3.2)  No (Skip to Q4)   List Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * 1. Will this affect your ability to do gentle exercise or participate in a group setting?  Yes (Excluded)  No (Go to Q4)   \*\*Please note you are advised not to participate in the exercises if experiencing rigidity, slow movement, tremors, postural instability, or any pain or discomfort\*\* | | |
| 1. **Any Condition that may limit Participation**     1. Do you have a medical condition that might mean you can’t do gentle exercises  Yes (Excluded)  No | | |
| 1. **Do you live in the community or in an independent living unit?**  Yes  No (Excluded) | | |
| 1. **Can you attend an English speaking group?**  Yes  No    1. If No; what language? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| Emergency Contact: Phone :( H) ( M):  Relationship: | | |
| GP’s name: GP’s phone:  GP’s address Postcode | | |
| **Inform caller –** Your details have been entered into our database and an information pack will be sent.  You will be contacted when the next group is due to start, please bear in mind that this can take some time.  Email: [seslhd-steppingon@health.nsw.gov.au](mailto:seslhd-steppingon@health.nsw.gov.au) Fax: 9540 8292 | | |