**Stepping On Workshop Registration Form**

**Thursdays from August 26 – October 7, 9:30am – 11:30am**

**The Shul
8825 N Lake Drive
Bayside
414-228-8000**

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 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:

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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

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7. How did you hear about the Stepping On workshop?

 \_\_\_\_ friend \_\_\_\_ health care provider \_\_\_brochure (where picked up?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_family member \_\_\_\_ other (please specify)

[8. INCLUDE THIS QUESTION ONLY IF HAVE CAPABILITY TO ASSIST: Will you need transportation assistance in getting to the workshop? YES NO]

[9. INCLUDE ONLY IF RELEVANT: Please note that there is a $\_\_\_ fee for this workshop. Please bring the fee to the first session of the workshop. If you are writing a check, make it payable to: \_\_\_\_\_. Please note that we are not able to take credit cards.]

[NOTE TO INDIVIDUAL TAKING REGISTRATIONS:

a. If taking registration by phone or in person, please ensure that individual is cognitively intact.

b. If someone other than the older adult is registering “for” him or her, please determine why the older adult is not registering him or herself. Concerns include: positive cognitive problems, an unwilling or reluctant participant.]

PRINT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 the Wisconsin Institute for Healthy Aging (WIHA) 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

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* Yes
* No

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* Yes
* No