



Lindsborg  
Community Hospital

Salina Regional Health Center

Partners caring for the health of  
the Smoky Valley communities.

**Registration Form**  
**Stepping On Workshop**  
**Tuesdays, September 18 - October 30, 2018**  
**9:30 am-11:30 am**  
**Bethany Lutheran Church, Martin Luther Room**

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:

\_\_\_\_\_

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 \_\_ internet \_\_ other (please specify) \_\_\_\_\_

8. Will you need transportation assistance in getting to the workshop? YES NO

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

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

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

**Please mail form to:**

Lindsborg Community Hospital

ATTN: Cynthia Woodard

605 W. Lincoln

Lindsborg, KS 67456

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) and Lindsborg Community Hospital (LCH) 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

\_\_\_\_\_  
Signature