Appendix: Fall Interview Survey

1. Are you able to understand and speak English or Hebrew?

* Yes
* No

2. Are you 18 years old or older?

* Yes
* No

3. Do you have a diagnosis of Multiple Sclerosis?

* Yes
* No

4. Do you primarily use a wheelchair or scooter when doing activities outside of your home?

* Yes
* No

5. When you transfer, (move from one surface to another, such as moving from your wheelchair to a bed), are you able to perform at least 25% of the work?

* Yes
* No

6. What gender do you most closely identify with?

* Male
* Female

7. Please enter your relationship status

* Married
* Single
* Divorced/Separated
* Widow/Widower
* Living with significant other
* Other
* Rather not say

8. Please enter your age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. What type of Multiple Sclerosis are you living with?

* Relapsing/Remitting
* Primary Progressive
* Secondary Progressive
* Progressive-Relapsing

10. Assistive device use (Please check all that apply)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Use of device | | Details of use | | | Have you fallen using this type of device? | |
|  | Yes | No | Hours Used Per Week | Activities performed with device | Year Began Using | Yes | No |
| Power Wheelchair |  |  |  |  |  |  |  |
| Manual Wheelchair |  |  |  |  |  |  |  |
| Scooter |  |  |  |  |  |  |  |
| Walker |  |  |  |  |  |  |  |
| Cane |  |  |  |  |  |  |  |
| Other (please describe) |  |  |  |  |  |  |  |
| Other (please describe) |  |  |  |  |  |  |  |
| Other (please describe) |  |  |  |  |  |  |  |

11. Have you fallen, at least once, in the past six months?  (Fall = Unintentionally coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest on furniture, walls or other objects)

* Yes
* No

12. How many falls have you experienced the past six months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Have you sustained an injury as a result of a fall?

* Yes
* No

14. Did you contact a medical professional about the injury you sustained as a result of a fall?

* Yes
* No

15. Where did your most recent fall occur?

* Inside your home
* Inside a family member/friend's house
* Restaurant
* Store
* Exercise facility
* Porch
* Outside
* Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16. If you sustained a fall inside of your home, in what location of your home did the fall occur? (most recent fall)

* Living Room/Family Room/Sitting Room
* Kitchen
* Bathroom
* Bedroom
* Dinning Room
* Attic
* Basement
* Hallway
* Stairs
* Other (please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17. What activity where you performing when the fall occurred? (most recent fall) - Please check all that apply

* transferring (moving from one surface to another, such as from a wheelchair to a bed)
* walking
* walking up/down stairs
* reaching for an object
* getting dress/undressed
* moving around in bed
* taking a shower/bath
* cooking/food preparation
* cleaning
* shopping
* lifting a heavy object
* using the toilet
* pushing a manual wheelchair inside a home
* driving a power wheelchair inside a home
* driving a scooter inside a home
* pushing a manual wheelchair outside of a home
* driving a power wheelchair outside of a home
* driving a scooter outside of a home
* being pushed in a wheelchair
* transferring into/out of a car
* Other (Please describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

18. Do you have any concerns about of falling?

* yes
* No

19. Do you limit the activities you perform due to concerns about falling?

* yes
* No

20. How many hours per week do you typically use your wheeled mobility device?

\_\_\_\_\_\_ Hours per week