Appendix I

Self-Reported Exercise-Related Injury Questionnaire in Older Adults
<TIMEPOINT>

We would like to ask you about your history of exercise-related injury since <TIMEPOINT>: Please check the box that applies to you.

1. In the last <TIMEPOINT>, have you had an injury that occurred while you were participating in <exercise-type>?

   □ Yes (If Yes, please continue on to Question #2)
   □ No (If No, you are done)

2. Have you had more than one injury participating in <exercise-type> in the last <TIMEPOINT>?

   □ Yes; If Yes, how many injuries? __________________
   □ No

The following questions refer to the most serious exercise-related injury you experienced in the last <TIMELINE>.

3. When in the <TIMELINE> did the injury occur? ________________

4. To which part of the body did the injury occur? (Please check and underline all that apply)

   □ Head and/or Neck
   □ Lower Extremity (thigh, lower leg, ankle, and/or foot)

   □ Upper Extremity (upper arm, forearm, hand and/or wrist)
   □ Multiple Body Regions

   □ Trunk (chest, upper back, lower back, abdomen, spine, and/or pelvis)
   □ Other ____________________
5. What **type** of injury did you have?

- Muscle strain (while you were exercising)
- Muscle strain (over time / repetitive)
- Sprain (joint / ligament e.g. ankle sprain)
- Bruise and/or abrasion
- Cut and/or laceration
- Bone fracture
- Head injury
- Other __________________________

6. What was the **cause** of your injury?

- Fall
- Overexertion or strenuous movement
- Overuse or repeated strain
- Fatigue
- Struck by an object
- Dizziness
- Aggravated old injury
- Other __________________________

7. What **type of exercise** were you doing when the injury occurred?

- Walking
- Jogging
- Aerobics
- Step-Aerobics
- Stretching
- Chair Exercises
- Strength Training- Weight Machines
- Strength Training- Hand Held Weights
- Strength Training- Therabands
- Stability Ball Exercises
- Floor Exercises (abdominal/back)
- Other __________________________

8. In what **location** did the injury occur?

- Gymnasium
- Weight Room
- Locker Room
- Sidewalk
- Walking / Bike Path
- Other __________________________
9. Did your injury require medical care or treatment?
   □ Yes
   □ No

10. If yes, where did you first receive care for your injury?
   □ On-site, staff
   □ On-site, ambulance
   □ Hospital emergency room
   □ Family / Private physician
   □ Outpatient facility / Walk-in Clinic
   □ Physical Therapist
   □ Other _____________________

11. Was the injury serious enough to limit your normal activities when you returned home?
   □ Yes  (If yes, please describe below)

   □ No

   ____________________________________________________________
   ____________________________________________________________

12. Were you able to continue participating in exercise-type activities?
   □ Yes

   □ No; If No, how much time passed before you could resume participating in your exercise routine? ____________________ (days)