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Article

Care Partner Physical Activity Attitudes and Practices on Perceived Physical Activity Benefits for Older Adults

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Abstract

Background: Care partners play a critical role in supporting physical activity among older adults. This study assesses how care partners' attitudes to and engagement in physical activity relate to their perceived benefits of exercise for older adults. **Methods:** For this cross-sectional study, 305 care partners completed validated surveys on the perceived benefits of physical activities among older adults (outcome), attitudes towards, and practices of physical activities (predictors). For all three surveys, higher scores indicate greater perceived benefit, more positive attitudes, and greater engagement in physical activities. We assessed the relationship between the predictor and outcome variables using multivariable quantile regression models adjusted for sociodemographic, caregiving, and health-related covariates. We reported the adjusted median difference (aMD) and 95% confidence intervals (CI). **Results:** The population was predominantly young adults (18-34 years, 58%), female (53%), who had been providing caregiving services for three or more years (43%). The median perceived physical activity benefit for older adults, personal attitude toward physical activity, and physical activity practice scale scores were 60.0 (52.0 – 66.0), 29.0 (25.0 – 33.0), and 33.0 (28.0 – 39.0), respectively. After adjusting for covariates, a unit increase in both attitude towards physical activity (aMD: 1.14; 95% CI: 0.96 – 1.33) and physical activity practice (aMD: 0.60; 95% CI: 0.45 – 0.75) was associated with increased median score of perceived benefit of physical activity among older adults. **Conclusion:** Care partners with positive attitudes and greater engagement in their personal physical activity perceive physical activities as beneficial for older adults.

Keywords: care partners; older adults; physical activity; perception; attitude; practice; knowledge; attitude; practice

1. Introduction

Regular physical activity and exercise (hereafter referred to as physical activity) is one of the most effective strategies for maintaining health, independence, and quality of life in older adults [1,2]. Physical activity reduces the risk and severity of chronic diseases [3,4], preserves mobility and

cognitive function [5,6], prevents falls [7], and lowers mortality [8–10]. Despite these well-documented benefits, physical activity and exercise remain markedly low among older adults [8].

Care partners, defined as family members, neighbors, or friends who assist older adults with daily activities [11], play a critical role in influencing health behaviors among care recipient older adults, including physical activity [12,13]. Their perceptions and beliefs on physical activity and exercise may influence the care recipients' knowledge, attitudes toward, and engagement in physical activity and exercise. A positive care partner's view of engagement in physical activity and exercise may influence the care recipient's perception of these activities as feasible, safe, or worth prioritizing. On the other hand, a care partner's negative attitude toward physical activity may dissuade the care recipient from engaging in it.

One way to evaluate care partners' attitudes and practices regarding physical activity is through the Knowledge, Attitudes, and Practices (KAP) behavioral model. The KAP model, widely applied across multiple health behavior domains [14–22], posits that individuals first acquire knowledge, which then shapes their attitudes and ultimately informs their practices [23]. Although the KAP model traditionally assumes that knowledge influences attitudes, which in turn influence practices [23], a dyadic framework introduces an additional mechanism. Individuals may generalize the benefits or harms they personally experience and project them onto their dyadic partners [24]. Specifically, within a care partner–care recipient framework, care partners' experiential benefits, shaped by their own knowledge of, attitudes toward, and engagement in physical activity, may inform their perceptions of the potential benefits of their care recipients' engagement in physical activity.

This study, therefore, centers on a key yet underexplored question: Do care partners with more positive attitudes toward and greater engagement in physical activity view such activities as beneficial for their older care recipients? Understanding how care partners' attitudes and practices shape their perceptions of the benefits of physical activity for older adults can inform interventions to promote physical activity among older adults. The aim of this study, therefore, is to assess how care partners' attitudes towards and engagement in physical activities relate to their perceived benefits of physical activities for older adults. We hypothesized that higher attitudinal and practice scores among care partners would be associated with higher perceived benefits of physical activity for older adults.

2. Materials and Methods

Study Design and Participants

We conducted a cross-sectional online survey study of care partners of older adults enrolled in the pilot and validation phase of the Activity Tracking, Care Partner Co-Participation, Text Reminders, Instructional Education, Virtual Physical Therapy, and Exercise (ACTIVE) study. Study participants were recruited through ResearchMatch, a national online registry supported by the National Institutes of Health that connects individuals interested in research with investigators [25]. Recruitment notices were distributed via the platform's email listserv, and eligible participants who consented to participate completed the survey. All data were collected using REDCap, a secure, web-based data management system [26].

Eligibility Criteria

Care partners were eligible if they were aged 18 years or older, provided ongoing, unpaid support to an older adult aged 65 years or older, could read English, and had internet access to complete the survey. The exclusion criteria included individuals who served in a formal or paid caregiving capacity and those who indicated difficulty completing the online questionnaire due to cognitive, sensory, or communication limitations.

Outcome Variable

The main outcome was the physical activity benefits for older adults, assessed using the Perceived Physical Activity Benefits for Older Adults survey instrument (Appendix Table A1). The survey instrument comprises 14 items that assess understanding of the health, functional, and

cognitive benefits, as well as awareness of exercise guidelines for older adults. The instrument, scored from 14 to 70, has been validated among care partners and demonstrates strong internal consistency in (Cronbach alpha (α) = 0.88). Higher scores reflected greater perceived benefit of exercise for older adults.

Predictor Variables

Our predictor variables were attitude towards physical activity and physical activity engagement (Appendix Table A1). Attitude was measured using the Attitude toward Physical Activity Scale, a seven-item survey, scored from 7 to 35. Practice was measured using the Physical Activity Practice Scale, a nine-item survey scored from 9 to 45. Both instruments have been validated among care partners of older adults, and they exhibited good internal consistency (Attitude Scale: α = 0.86; Practice Scale: α = 0.76). Higher scores for both attitude and practice measures reflect more favorable attitudes and greater engagement in physical activity, respectively.

Potential Confounders

We adjusted for sociodemographic, caregiving, and health characteristics. Sociodemographic characteristics included age, sex, race/ethnicity, educational attainment, and marital status. Caregiving characteristics included relationship with care recipient (spouse, child/sibling, other relatives, and friend/neighbor), co-residence with the older adult, duration of caregiving (less than a year, 1 -2 years, and 3 or more years), and hours of caregiving per week (less than 10 hours, 10 – 19 hours, 20 – 39 hours, 40 hours or more). Health characteristics included self-rated health (fair/poor, good, very good/excellent) and the Charlson comorbidity index, a predictor of 10-year mortality, computed from 16 chronic diseases [27,28]. We computed the Charlson comorbidity index as a weighted sum of chronic diseases, ranging from 0 to 24, consistent with prior studies [29,30], and defined it as a continuous variable.

Missing Data

A total of 329 eligible care partners consented to participate in the survey, but 24 did not complete it. We deleted these 24 respondents because missingness was not at random [31], and large portions of the survey were unanswered. All remaining 305 respondents completed the survey.

Data Analysis

We reported the means and standard deviations (SD) and median and interquartile ranges (Q1, Q3) for continuous variables and frequencies and proportions for categorical variables. Of note, the perceived physical activity benefit score exhibited a non-normal distribution. Hence, for the bivariate association, we reported the median (Q1, Q3) distribution of the perceived physical activity benefit score across all categorical variables and assessed differences using Mann-Whitney U and Kruskal-Wallis tests. We created two separate multivariable models – a perceived benefit – attitude model (model 1) and a perceived benefit – practice model (model 2). We performed multivariable quantile regressions for each model to assess how care partners' attitudes towards and engagement in physical activity are associated with their perceived benefits of physical activity among older adults. For each model, we controlled for potential confounders and reported the adjusted median difference (aMD) and 95% confidence intervals (CI). All analyses were performed using Stata version 16 [32].

Ethical Considerations

The study protocol was approved by the NYU Langone Health Institutional Review Board (IRB# i25-00450; 08/21/2025). All participants provided electronic informed consent prior to participation. Study procedures adhered to ethical principles for human research and complied with institutional and federal guidelines.

3. Results

A total of 305 care partners participated in the study. The population was predominantly aged 18–34 years (58%), female (53%), non-Hispanic White (35%), married (78%), with college degrees (56%) (Table 1). Most of the care partners were spouses (28%), children or siblings (10%), or other family members (37%) of the older care recipients. Also, most of the care partners live with their older care recipient (80%), provide 10–19 hours of caregiving per week (35%), and have been caring for

their older care recipient for three or more years (43%). Also, most of the care partners had no comorbid conditions (84%), and 77% rated their health as very good or excellent. The median (IQR) Physical Activity Benefit Scale score was 60.0 (52.0 – 66.0) while the Attitude towards Physical Activity Scale and Physical Activity Practice Scale scores were 29.0 (25.0 – 33.0) and 33.0 (28.0 – 39.0), respectively.

Several sociodemographic and caregiving characteristics were significantly associated with the Physical Activity Benefit Scale score, with higher scores among care partners aged 18–34 years ($p < 0.001$), non-Hispanic Blacks ($p < 0.001$), and those with graduate degrees ($p < 0.001$) (Table 2). Significant bivariate relationships were also observed with marital status ($p = 0.003$), relationship with the care recipient ($p = 0.002$), hours per week spent on caregiving ($p < 0.001$), comorbidity index ($p < 0.001$), and self-rated health ($p < 0.001$).

After adjusting for potential confounders in the Perceived Benefit – Attitude model, a unit increase in the Attitude towards Physical Activity score was associated with a significant increase in the median difference in Perceived Physical Activity Benefit score (Model 1; aMD: 1.17; 95% CI: 0.99 – 1.35, Table 3). Also, after adjusting for potential confounders in the Perceived Benefit – Practice model, a unit increase in the Physical Activity Practice score was associated with a significant increase in the median difference in Perceived Physical Activity Benefit (Model 2; aMD: 0.60; 95% CI: 0.45 – 0.75). The predicted Physical Activity Benefit score increased linearly with every unit increase in the attitude (Figure 1A) and the practice scores (Figure 1B).

Table 1. Sociodemographic, health, and behavioral characteristics among care partners of older adults (N=305).

Variables	Frequency / Summary Statistics
<i>Demographic Characteristics</i>	
Age (Mean, SD)	35.3 (10.1)
18 – 34 years	176 (57.7)
35 – 64 years	114 (37.4)
65 years and older	15 (4.9)
Sex	
Male	144 (47.2)
Female	161 (52.8)
Race/Ethnicity	
Non-Hispanic White	107 (35.1)
Non-Hispanic Black	90 (29.5)
Hispanic	92 (30.2)
Other Races	16 (5.2)
Highest Educational Degree	
High School Diploma	64 (21.0)
College Degree	170 (55.7)
Graduate Degree	71 (23.3)
Marital Status	
Married	239 (78.4)
Never Married	35 (11.5)
Widowed/Separated/Divorced	31 (10.1)
<i>Social Characteristics</i>	
Relationship with Care Recipient	
Spouse	86 (28.2)

Child/Sibling	31 (10.2)
Other Relatives	113 (37.0)
Friend/Neighbor	75 (24.6)
Living Situation	
Living with care recipient	243 (79.7)
Not living with care recipient	62 (20.3)
Length of Caregiving	
Less than a year	67 (21.9)
1 – 2 years	106 (34.8)
3 years or more	132 (43.3)
Hours/Week Spent on Caregiving	
Less than 10 hours	86 (28.2)
10 – 19 hours	108 (35.4)
20 – 39 hours	94 (30.8)
40 hours or more	17 (5.6)
<hr/>	
<i>Health Characteristics</i>	
Charlson Comorbidity Score	
0	257 (84.3)
1	30 (9.8)
2 or more	18 (5.9)
Self-Rated Health	
Fair/Poor	234 (76.7)
Good	55 (18.0)
Very Good/Excellent	16 (5.3)
<hr/>	
<i>Behavioral Characteristics</i>	
PABS Score	60.0 (52.0 – 66.0)
APAS Score	29.0 (25.0 – 33.0)
PAPS Score	33.0 (28.0 – 39.0)

¹ Perceived Physical Activity Benefit Scale Score: PABS Score; Attitude towards Physical Activities Scale Score: APAS Score; Physical Activity Practice Scale Score: PAPS Score.

Table 2. Bivariate association between perceived physical activity benefits for older adults and sociodemographic and health characteristics of care partners (N=305).

Variables	PABS Score	p-value
<i>Demographic Characteristics</i>		
Age Categories		
18 – 34 years	61.0 (55.0 – 68.0)	<0.001 [#]
35 – 64 years	57.0 (51.0 – 63.0)	
65 years and older	58.0 (39.0 – 61.0)	
Sex		
Male	60.0 (52.0 – 68.0)	0.327 ^{##}
Female	59.0 (53.0 – 65.0)	
Race/Ethnicity		

Non-Hispanic White	60.0 (56.0 – 65.0)	<0.001#
Non-Hispanic Black	67.0 (61.0 – 70.0)	
Hispanic	50.0 (45.0 – 57.0)	
Other Races	59.0 (58.0 – 60.5)	
Highest Educational Degree		
High School Diploma	57.0 (54.0 – 60.0)	<0.001#
College Degree	58.5 (48.0 – 65.0)	
Graduate Degree	66.0 (61.0 – 70.0)	
Marital Status		
Married	60.0 (51.0 – 66.0)	0.003#
Never Married	60.0 (59.0 – 66.0)	
Widow/Separated/Divorced	56.0 (52.0 – 60.0)	
<hr/> <i>Social Characteristics</i>		
Relationship with Care Recipient		
Spouse	59.5 (46.0 – 68.0)	0.002#
Child/Sibling	56.0 (47.0 – 60.0)	
Other Relatives	60.0 (55.0 – 64.0)	
Friend/Neighbor	63.0 (56.0 – 68.0)	
Living Situation		
Living with care recipient	60.0 (56.0 – 65.0)	0.550##
Not living with care recipient	59.0 (52.0 – 66.0)	
Length of Caregiving		
Less than a year	61.0 (57.0 – 65.0)	0.238#
1 – 2 years	59.0 (50.0 – 66.0)	
3 years or more	58.0 (52.0 – 66.5)	
Hours/Week Spent on Caregiving		
Less than 10 hours	66.5 (59.0 – 70.0)	<0.001#
10 – 19 hours	57.0 (51.5 – 62.0)	
20 – 39 hours	58.0 (48.0 – 65.0)	
40 hours or more	59.0 (53.0 – 62.0)	
<hr/> <i>Health Characteristics</i>		
Charlson Comorbidity Score		
0	60.0 (55.0 – 66.0)	<0.001#
1	49.5 (43.0 – 58.0)	
2 or more	53.0 (49.0 – 60.0)	
Self-Rated Health		
Fair/Poor	60.0 (53.0 – 67.0)	<0.001#
Good	58.0 (47.0 – 60.0)	
Very Good/Excellent	59.5 (55.0 – 64.5)	

#: Kruskal-Wallis test performed; ##: Mann-Whitney U test performed. Perceived Physical Activity Benefit Scale Score: PABS Score;

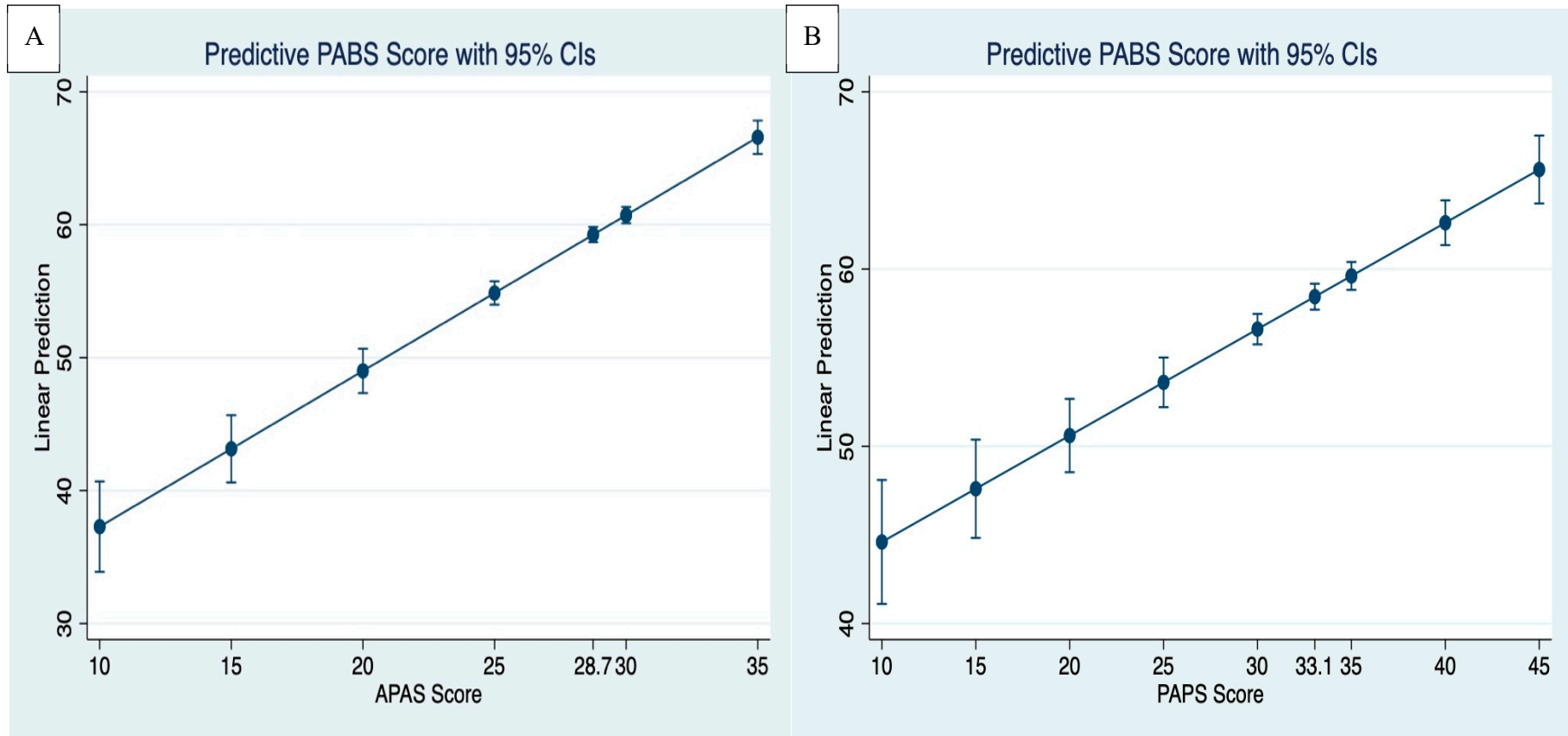


Figure 1. Predicted estimates of perceived physical activity benefit score for older adults (PABS Score) and personal (A.) attitude towards physical activities (APAS) and (B.) engagement in physical activities using the physical activity practice scale (PAPS Score). Each model adjusted for age, sex, race/ethnicity, educational attainment, marital status, relationship with care recipient, living situation, length of caregiving, weekly duration of caregiving, self-rated health, and Charlson comorbidity index.

Table 3. Multivariable quantile regression models between perceived physical activity benefits for older adults and personal attitudes towards and engagement in physical activities (N=305).

Variables	Model 1: PABS - APAS	Model 2: PABS - PAPS
	Coeff (95% CI)	Coeff (95% CI)
<i><u>Predictor Variables</u></i>		
APAS Score	1.17 (0.99, 1.35)	
PAPS Score		0.60 (0.45, 0.75)
<i><u>Demographic Characteristics</u></i>		
Age	0.11 (0.03, 0.18)	0.05 (-0.04, 0.15)
Sex		
Male	-0.18 (-1.44, 1.08)	-0.92 (-2.54, 0.70)
Female	Ref	Ref
Race/Ethnicity		
Non-Hispanic White	Ref	Ref
Non-Hispanic Black	1.71 (-0.11, 3.54)	0.26 (-2.12, 2.63)
Hispanic	-4.78 (-6.68, -2.88)	-8.87 (-11.16, -6.58)
Other Races	0.77 (-2.16, 3.69)	1.43 (-2.28, 5.15)
Highest Educational Degree		
High School Diploma	Ref	Ref
College Degree	-2.57 (-4.27, -0.87)	-2.01 (-4.27, 0.26)
Graduate Degree	-1.43 (-3.56, 0.70)	-0.36 (-3.30, 2.47)
Marital Status		
Married	Ref	Ref
Never Married	-0.93 (-3.21, 1.36)	1.21 (-1.71, 4.14)
Widow/Separated/Divorced	-1.79 (-3.97, 0.40)	-1.36 (-4.16, 1.45)
<i><u>Social Characteristics</u></i>		
Relationship with Care Recipient		
Spouse	Ref	Ref
Child/Sibling	0.07 (-2.20, 2.35)	0.76 (-3.67, 2.15)
Other Relatives	0.89 (-0.80, 2.57)	0.74 (-1.42, 2.90)
Friend/Neighbor	0.64 (-1.27, 2.55)	0.94 (-1.50, 3.39)
Living Situation		
Living with care recipient	-1.01 (-2.71, 0.68)	-1.10 (-3.27, 1.08)
Not living with care recipient	Ref	Ref
Length of Caregiving		
Less than a year	Ref	Ref
1 – 2 years	-1.59 (-3.34, 0.16)	-2.53 (-4.78, -0.27)
3 years or more	-1.40 (-3.08, 0.28)	-1.20 (-3.36, 0.96)
Hours/Week Spent on Caregiving		
Less than 10 hours	Ref	Ref

10 – 19 hours	-2.28 (-4.04, -0.53)	-1.98 (-4.25, 0.28)
20 – 39 hours	-1.90 (-3.74, -0.08)	-2.83 (-5.18, -0.49)
40 hours or more	-4.14 (-7.32, -0.96)	-3.67 (-7.13, 0.39)
<i>Health Characteristics</i>		
Charlson Comorbidity Score	-0.37 (-1.05, 0.32)	-1.32 (-2.19, -0.44)
Self-Rated Health		
Fair/Poor	2.13 (-0.66, 4.92)	4.28 (0.61, 7.94)
Good	2.01 (0.29, 3.72)	1.65 (-0.55, 3.86)
Very Good/Excellent	Ref	Ref

Model 1: PABS – APAS; Model assessing the association between the Perceived Physical Activity Benefit Scale for older adults Score (PABS Score) and Attitude towards Physical Activities Scale Score (APAS Score); Model 2: PABS – PAPS; Model assessing the association between the Perceived Physical Activity Benefit Scale for older adults Score (PABS Score) and Physical Activity Practice Scale Score (PAPS Score). Each model controlled for the listed sociodemographic and health characteristics. Coeff: Coefficient.

4. Discussion

In this cross-sectional study of care partners, we found that individuals who reported more positive attitudes toward physical activity and greater personal engagement in exercise were also more likely to endorse stronger beliefs in the benefits of physical activity for older adults. These findings suggest that care partners' own behaviors and attitudes may reinforce their understanding of the value of physical activity, potentially influencing how they encourage, model, or facilitate physical activity for older care recipients [33].

Prior research has identified a range of factors that influence older adults' physical activity. These include but are not limited to clinical factors (such as chronic medical conditions, pain, and functional limitations) [34–37], psychological factors (such as knowledge, attitudes, self-efficacy, motivation, and fear of falling) [38,39], and environmental factors (such as neighborhood safety and walkability, access to parks and gyms, home environment, weather, and transportation [39–42].

Care partner encouragement and exercise behavior modeling have also been identified as important facilitators of older adults' engagement in physical activity [43]. Our findings extend this literature by highlighting that not only do older adults' own attitudes matter, but the attitudes and behaviors of the people who support them may play a complementary role.

A conceptual explanation may account for how care partners' attitudes and engagement in physical activity associate with their perceived benefits of exercise among older adults. Care partners who regularly participate in physical activity are directly exposed to its benefits, which can shape their beliefs about exercise and its value for themselves and potential benefits for their older adult care recipient. Likewise, those with positive attitudes toward physical activities may be more likely to pay attention to information on the benefits of physical activity among older adults. In this way, a care partner's own attitudes and practices are both behavioral expressions of self-acquired knowledge, consistent with the KAP model [23], and serve as meaningful predictors of perceived benefits of physical activity among older adults, which may then influence behavioral change among their older adult care recipients.

These findings have several implications. First, promoting physical activity among older adults may require leveraging the presence of care partners with positive attitudes towards and engagement in physical activity. Secondly, interventions that enhance care partners' knowledge, foster positive attitudes, and encourage their own engagement in exercise may strengthen older care recipients' participation in physical activity [44,45]. Third, clinicians' and health educators' encouragement is an important motivational factor in older adults' engagement in physical activity [46,47]. Incorporating care partners with positive attitudes and strong engagement in physical activity into counseling and activity planning may further strengthen older adults' motivation to participate. More broadly,

programs that promote caregiver wellness, facilitate active lifestyles, and reduce barriers to physical activities may produce ripple effects that extend to both older adults and their care partners.

Our study has its limitations. Our cross-sectional design does not permit causal inference. Our sample was recruited from an online registry, which may overrepresent individuals with greater interest in health research or higher digital literacy, thereby limiting generalizability. All measures were self-reported and, therefore, susceptible to self-report and social desirability bias [48,49]. Although we controlled for sociodemographic, health, and care partner-care recipient measures, other measures, such as broader social network, community or environmental supports, and access to caregiving resources, may influence care partners' perceived benefits of exercise among older adults. Despite these limitations, our study represents one of the few studies that provides insights into how care partners' attitudes towards and engagement in physical activities associate with their perceived physical activity benefits among older adults.

5. Conclusions

Care partners who hold more favorable attitudes toward physical activity and engage in it are more likely to perceive it as highly beneficial for older adults. These findings highlight the intertwined nature of caregiver and care recipient health behaviors and suggest that strategies and interventions that promote physical activity in older adults may be strengthened by addressing the beliefs and practices of their care partners.

Author Contributions: Conceptualization, O.A.; Methodology, O.A.; Software, O.A., J.C.; Formal Analysis, O.A.; Data Curation, O.A.; Writing – Original Draft Preparation, O.A.; Writing – Review & Editing, O.A., T.C., G.O., D.B., J.C.; Visualization, O.A.; Supervision, J.C.

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Institutional Review Board Statement: This study was reviewed and approved by the NYU Langone Health Institutional Review Board (IRB#: i25-00450; 08/21/2025).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: The original data presented in the study are openly available in FigShare at 10.6084/m9.figshare.30801278.

Conflicts of Interest: The authors declare no conflicts of interest.

Abbreviations

The following abbreviations are used in this manuscript:

PBAS	Perceived Physical Activity Benefit Scale for older adults
APAS	Attitude towards Physical Activity Scale
PAPS	Physical Activity Practice Scale
ACTIVE	Activity Tracking, Care Partner Co-Participation, Text Reminders, Instructional Education, Virtual Physical Therapy, and Exercise
KAP	Knowledge, Attitudes, and Practices
aMD	Adjusted Median Difference
CI	Confidence Interval

Appendix A

Table A1. List of the items in the Perceived Physical Activity Benefit Scale for older adults, Attitude towards Physical Activity Scale, and Physical Activity Practice Scale .

Perceived Physical Activity Benefits Scale (PABS)

Regular physical activity is essential for maintaining good health in older adults.

Older adults who engage in physical activity experience improved quality of life.
 Exercise helps older adults maintain independence in daily activities.
 Engaging in regular exercise reduces the risk of premature death in older adults.
 The benefits of exercise outweigh the risks for most older adults.
 Regular physical activity improves heart health and reduces the risk of cardiovascular disease.
 Strength training exercises help prevent osteoporosis and maintain bone health.
 Exercise can reduce the risk of falls by improving strength and balance.
 Regular exercise enhances cognitive function and reduces the risk of dementia.
 Physical activity can help manage chronic conditions such as diabetes and arthritis.
 Older adults should engage in at least 150 minutes of moderate-intensity physical activity per week.
 Strength training exercises should be performed at least twice a week for older adults.
 Even light-intensity activities, such as walking, provide significant health benefits for older adults.
 It is never too late for older adults to start exercising and gain health benefits.

Attitude Towards Physical Activities Scale (APAS)

I enjoy engaging in physical activity.
 Exercise is an important part of a healthy lifestyle.
 I feel motivated to exercise regularly.
 I believe I can still benefit from exercise regardless of my age.
 Exercising with others makes it more enjoyable for me.
 I would be more likely to exercise if I had proper guidance.
 Encouragement from family or friends increases my likelihood of exercising.

Physical Activity Practice Scale (PAPS)

I engage in physical activity at least 3 times a week.
 I perform strength-training exercises at least twice a week.
 I engage in moderate-to-vigorous physical activity for at least 150 minutes per week.
 I incorporate light physical activities (e.g., walking, stretching) into my daily routine.
 I participate in group-based or social exercise programs.
 I do balance or flexibility exercises to prevent falls.
 I track my physical activity levels using a device or app.
 My healthcare provider has advised me (or the older adult I care for) to exercise regularly.
 I (or the older adult I care for) follow an exercise plan or routine.

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