

Program Name

Participant Information Survey

Admin Use Only: Participant I.D.: The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.

State abbreviation: ___ ___ (e.g., NY, VA, etc.)

First four letters of the site name: ___ ___ ___ ___

Start date of program: ___ ___ / ___ ___ / ___ ___ (e.g., 12/01/19)

Participant number: ___ ___ (e.g., 01, 02, 03, etc.)

1. Did your doctor or other health care provider suggest that you take this program?
 Yes No
2. How old are you today? _____ years
3. Are you: Male or Female?
4. Are you of Hispanic, Latino, or Spanish origin? Yes No
5. What is your race? Mark all that apply.
 American Indian or Alaska Native
 Asian
 Black or African American
 Native Hawaiian or other Pacific Islander
 White
6. Are you deaf or do you have serious difficulty hearing? Yes No
7. Are you blind or do you have serious difficulty seeing even with glasses?
 Yes No
8. Do you live alone? Yes No
9. What is the highest grade or year of school you completed?
 Some elementary, middle, or high school
 High school graduate or GED
 Some college or technical school
 College 4 years or more
10. Have you ever served in the military?
 Yes No
11. During the past year, did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability? Yes No

12. For whom are you attending this program?

- Myself Accompanying someone else Both

13. In general, would you say that your health is:

- Excellent Very good Good Fair Poor

14. Has a health care provider ever told you that you have any of the following chronic conditions?

	YES	NO		YES	NO
Anxiety Disorder			Chronic Pain		
High Cholesterol			Kidney Disease		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Obesity		
Hypertension (High Blood Pressure)			Schizophrenia or Other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Arthritis/Rheumatic Disease		
Heart Disease			Other Chronic Condition		

15. Because of a physical, mental, or emotional condition, do you:

- Have serious difficulty walking or climbing stairs? Yes No
- Have difficulty dressing or bathing? Yes No
- Have difficulty doing errands alone such as visiting a doctor's office or shopping?
 Yes No

16. How often do you feel lonely or isolated from those around you?

- Always Often Sometimes Rarely Never

17. How confident are you that you can manage your chronic condition(s).

Not confident at all 1 2 3 4 5 6 7 8 9 10 Totally confident

TO BE COMPLETED AT LAST PROGRAM SESSION

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First four letters of the site name: __ __ __ __

Start date of program: __ __ / __ __ / __ __ (e.g., 12 01 19)

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1. In general, would you say that your health is:

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2. How confident are you that you can manage your chronic condition(s).

Not confident at all 1 2 3 4 5 6 7 8 9 10 Totally confident

3. How often do you feel lonely or isolated from those around you?

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Paperwork Reduction Act Public Burden Statement:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-0036). Public reporting burden for this collection of information is estimated to average .20 hours per response, including time for gathering and maintaining the data needed and completing and reviewing the collection of information. The obligation to respond to this collection is required to retain or maintain benefits under the statutory authority of Public Law 115-245.