By filling out this form, I agree that the information collected on program forms may be studied and shared, with no way to link it back to me.

OMB Control No. 0985-0036
Exp. Date 11/22/2022

***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: N C (e.g., NY, VA, etc.)

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

Start date of program: __ __ / __ __ / 2 0 (e.g., 12/01/19)

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

*program name and all admin fields are required

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1. Did your doctor or other health care provider suggest that you attend 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?~~ ~~O Yes~~ ~~O No~~
7. Are you blind or do you have serious difficulty seeing, even when wearing 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

Reset Survey Questions Page 1 Only | Reset Pre Admin Fields Only

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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. In general, would you say that your health is:
◯Excellent ◯Very good ◯Good ◯Fair ◯Poor

13. 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	☐	☐

14. Because of a physical, mental, or emotional condition, do you:
    - Have serious difficulty concentrating, remembering, or making decisions?
      ◯Yes ◯No
    - Have difficulty doing errands alone such as visiting a doctor's office or shopping?
      ◯Yes ◯No

15. Do you have serious difficulty walking or climbing stairs? ◯Yes ◯No

16. Do you have difficulty dressing or bathing? ◯Yes ◯No

17. How often do you feel lonely or isolated from those around you?
◯Always ◯Often ◯Sometimes ◯Rarely ◯Never

18. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 ◯ Totally sure

Reset Survey Questions Page 2 Only **Print This Survey**