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: __ __ (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.)

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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? ☐ Yes ☐ 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

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
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	