Your Program Name

OMB Control No. 0985-XXXX
Exp. Date XX/XX/201

Participant Information Survey

Instructions: **Please use a pen to answer the questions on both sides of this form. Please print clearly. Mark your choice within the box, like this: ☒**

Your Name (or other way to identify you): _____

1. What is your date of birth? ☐☐ / ☐☐ / ☐☐☐☐

Month **Day** **Year**

2. What is your ZIP code? ☐☐☐☐☐

3. What is your sex?

☐ **Female** ☐ **Male**

4. Are you of Hispanic, Latino, or Spanish origin?

☐ **Yes** ☐ **No** ☐ **Unknown**

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. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)

☐ **Alzheimer's or Related Dementia**
☐ **Arthritis/Rheumatic Disease**
☐ **Breathing/Lung Disease (Asthma, Emphysema, Bronchitis, etc.)**
☐ **Cancer or Cancer Survivor**
☐ **Chronic Pain**
☐ **Depression or Anxiety Disorders**
☐ **Diabetes**
☐ **Heart Disease**
☐ **High Cholesterol**
☐ **Hypertension (High Blood Pressure)**
☐ **Multiple Sclerosis**
☐ **Osteoporosis (Low Bone Density)**
☐ **Stroke**
☐ **Other Chronic Condition:**

_____

☐ **None (No Chronic Conditions)**

Please turn over ⇨

Your Name (or other way to identify you): _____

7. 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**

8. Are you limited in any way in any activities because of physical, mental, or emotional problems?

☐ **Yes** ☐ **No**

9. Today, how many people live in your household (including yourself)?

☐ **(Number of people)**

10. 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