

PROGRAM EXPERIENCE

1. Which of the following did you accomplish with your participation in this program (select all that apply):

- Improved overall health
- Improved endurance
- Improved balance/coordination
- Improved exercise knowledge
- Improved nutritional knowledge
- Reduced stress
- Increased energy
- Increased flexibility
- Increased strength
- Had fun/socialized
- Lost weight (_____ pounds)
- NONE OF THE ABOVE

2. How much do you feel each of the following contributed to improving your health or facilitating weight loss during this program?

	Did not contribute at all	Contributed very little	Contributed somewhat	Strongly contributed
Pedometer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Theraband	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group Sessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialization with other program participants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improved eating habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (_____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I do not feel as though this program improved my health or facilitated weight loss

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-xxxx . The time required to complete this information collection is estimated to average 4 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

GENERAL HEALTH

3. In general, would you say your health is:

- Excellent
- Very good
- Good
- Fair
- Poor

4. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

- | | |
|--|--|
| a. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf? | <input type="checkbox"/> Yes, limited a lot
<input type="checkbox"/> Yes, limited a little
<input type="checkbox"/> No, not limited at all |
| <hr/> | |
| b. Climbing several flights of stairs? | <input type="checkbox"/> Yes, limited a lot
<input type="checkbox"/> Yes, limited a little
<input type="checkbox"/> No, not limited at all |

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

- | | |
|--|--|
| a. Accomplished less than you would like. | <input type="checkbox"/> No, none of the time
<input type="checkbox"/> Yes, a little of the time
<input type="checkbox"/> Yes, some of the time
<input type="checkbox"/> Yes, most of the time
<input type="checkbox"/> Yes, all of the time |
| <hr/> | |
| b. Were limited in the kind of work or other activities. | <input type="checkbox"/> No, none of the time
<input type="checkbox"/> Yes, a little of the time
<input type="checkbox"/> Yes, some of the time
<input type="checkbox"/> Yes, most of the time
<input type="checkbox"/> Yes, all of the time |

Office on Women's Health (OWH)

Living Healthier, Living Longer

6. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

- a. Accomplished less than you would like.
- No, none of the time
 - Yes, a little of the time
 - Yes, some of the time
 - Yes, most of the time
 - Yes, all of the time

-
- b. Didn't do work or other activities as carefully as usual.
- No, none of the time
 - Yes, a little of the time
 - Yes, some of the time
 - Yes, most of the time
 - Yes, all of the time

7. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

8. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

- a. Have you felt calm and peaceful?
- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time

-
- b. Did you have a lot of energy?
- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time

-
- c. Have you felt downhearted and blue?
- All of the time
 - Most of the time
 - A good bit of the time

Office on Women's Health (OWH)

Living Healthier, Living Longer

-
- Some of the time
 - A little of the time
 - None of the time
-

9. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

- All of the time
 - Most of the time
 - A good bit of the time
 - Some of the time
 - A little of the time
 - None of the time
-







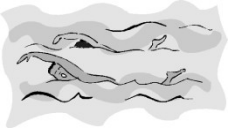



10. Now, we'd like to ask you some questions about how your health may have changed.

- a. Compared to one year ago, how would you rate your physical health in general now?
 - Much better
 - Slightly better
 - About the same
 - Slightly worse
 - Much worse

 - b. Compared to one year ago, how would you rate your emotional problems (such as feeling anxious, depressed or irritable) now?
 - Much better
 - Slightly better
 - About the same
 - Slightly worse
 - Much worse
-

PHYSICAL ACTIVITY

For questions 11 – 16 we are interested in your physical activity. Physical activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation. **Please refer to the following graphic for examples of physical activity intensity levels:**

<p>LIGHT activities</p> <ul style="list-style-type: none"> Your heart beats slightly faster than normal You can talk and sing 	 Walking leisurely	 Stretching	 Vacuuming; light yard work	
<p>MODERATE activities</p> <ul style="list-style-type: none"> Your heart beats faster than normal You can talk but not sing 	 Fast walking	 Aerobics class	 Strength training	 Swimming gently
<p>VIGOROUS activities</p> <ul style="list-style-type: none"> Your heart rate increases a lot You can't talk or your talking is broken up by large breaths 	 Stair machine	 Jogging or running	 Tennis, racquetball, or badminton	

11. During the last 7 days, on how many days did you do vigorous physical activities? Vigorous activities are activities during which your heart rate increases a lot and you can't talk (or talking is broken up by taking large breaths).

___ days per week

No vigorous physical activities (*skip to question 13*)

12. How much time did you usually spend doing vigorous physical activities on one of those days?

___ hours per day **or** ___ minutes per day

Don't know/not sure

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-xxxx. The time required to complete this information collection is estimated to average 4 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Office on Women's Health (OWH)

Living Healthier, Living Longer

13. During the last 7 days, on how many days did you do moderate physical activities? Do not include walking. Moderate activities are activities during which your heart beats faster than normal and you can talk but not sing.

___ days per week

No moderate physical activities (*skip to question 14*)

14. How much time did you usually spend doing moderate physical activities on one of those days?

___ hours per day **or** ___ minutes per day

Don't know/not sure

15. During the last 7 days, on how many days did you walk for at least 10 minutes at a time? Only include those instances where you walked continuously for at least 10 minutes.

___ days per week

No walking (*skip to question 17*)

16. How much time did you usually spend walking on one of those days?

___ hours per day **or** ___ minutes per day

Don't know/not sure

17. During the last 7 days, how much time did you spend sitting on a weekday? Remember to include time spent sitting at home, at work, in your leisure time, or in a car.

___ hours per day **or** ___ minutes per day

Don't know/not sure

18. Do you have any of the following negative feelings toward any exercise or exercise program the majority of the time? Please select all that apply.

I have no negative feelings toward exercise or exercise programs

Sweat makes me feel uncomfortable

I am uncomfortable in a gym

Exercise bores me

Exercise is exhausting

The information available about exercise is confusing

I feel as though I do not benefit from exercise

Exercise is too time-consuming

Exercise programs are expensive

I have been unsuccessful with previous exercise efforts

Other (please explain) _____

NUTRITION AND CONSUMPTION

FRUITS AND VEGETABLES

The next section is about the foods you consumed during the past month (i.e., the past 30 days), including meals and snacks.

19. During the past month, how many times per day, week or month did you drink 100% PURE fruit juices? Do not include fruit-flavored drinks with added sugar or fruit juice you made at home and added sugar to. Only include 100% juice.

_____ times per: Day
 Week
 Month
 Never
 Don’t know

20. During the past month, not counting juice, how many times per day, week or month did you eat FRUIT? Count fresh, frozen or canned fruit. Include apples, bananas, applesauce, oranges, grape fruit, fruit salad, watermelon, cantaloupe or musk melon, papaya, lychees, star fruit, pomegranates, mangos, grapes, and berries such as blueberries and strawberries.

_____ times per: Day
 Week
 Month
 Never
 Don’t know

21. During the past month, how many times per day, week, or month did you eat COOKED or CANNED BEANS, such as refried, baked, black, garbanzo beans, beans in soup, soybeans, edamame, tofu or lentils. Do NOT include long green beans.

_____ times per: Day
 Week
 Month
 Never
 Don’t know

22. During the past month, how many times per day, week or month did you eat DARK GREEN VEGETABLES for example broccoli or dark leafy greens including romaine, chard, collard greens or spinach?

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-xxxx . The time required to complete this information collection is estimated to average 4 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Office on Women's Health (OWH)

Living Healthier, Living Longer

- _____ times per:
- Day
 - Week
 - Month
 - Never
 - Don't know

23. During the past month, how many times per day, week or month did you eat ORANGE COLORED VEGETABLES such as sweet potatoes, pumpkin, winter squash or carrots? *Winter squash have hard, thick skins and deep yellow to orange flesh. They include acorn, buttercup, and spaghetti squash.*

- _____ times per:
- Day
 - Week
 - Month
 - Never
 - Don't know

24. Not counting questions 19-23, during the past month, about how many times per day, week or month did you eat OTHER vegetables? *Examples of other vegetables include tomatoes, tomato juice or V-8 juice, corn, eggplant, peas, lettuce, cabbage and white potatoes that are not fried such as baked or mashed potatoes.*

- _____ times per:
- Day
 - Week
 - Month
 - Never
 - Don't know

25. How many servings of fruits and vegetables do you usually have per day? (1 serving = 1 medium piece of fruit; ½ cup fresh, frozen or canned fruits/vegetables; ¾ cup fruit/vegetable juice; 1 cup salad greens; or ¼ cup dried fruit)

- 0 servings per day
- 1-2 servings per day
- 3-4 servings per day
- 5 or more servings per day

BEVERAGES

The next section is about the beverages you drank during the past month (i.e., the past 30 days). Remember to include any sweetened beverages used as a mixer.

26. During the past month, how often did you drink regular soda or pop that contains sugar? Do not include diet soda.

- _____ times per: Day

- Week
- Month
- Never (*skip to question 28*)
- Don’t know (*skip to question 28*)

27. Each time you drank soda or pop, how much did you usually drink?

- Less than 6 fl oz (3/4 cup)
- 8 fl oz (1 cup)
- 12 fl oz (1 1/2 cups)
- 16 fl oz (2 cups)
- More than 20 fl oz (2 1/2 cups)

28. During the past month, how often did you drink sports or energy drinks such as Gatorade, Red Bull and Vitamin Water? Do not include diet or sugar-free kinds.

- _____ times per:
- Day
 - Week
 - Month
 - Never (*skip to question 30*)
 - Don’t know (*skip to question 30*)

29. Each time you drank sports or energy drinks, how much did you usually drink?

- Less than 6 fl oz (3/4 cup)
- 8 fl oz (1 cup)
- 12 fl oz (1 1/2 cups)
- 16 fl oz (2 cups)
- More than 20 fl oz (2 1/2 cups)

30. During the past month, how often did you drink sweetened fruit drinks such as Kool-aid, cranberry drink and lemonade? Include fruit drinks you made at home and added sugar to. Do not include 100% fruit juices and drinks with things like Splenda or Equal.

- _____ times per:
- Day
 - Week
 - Month
 - Never (*skip to question 32*)
 - Don’t know (*skip to question 32*)

31. Each time you drank sweetened fruit drinks, how much did you usually drink?

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990-xxxx . The time required to complete this information collection is estimated to average 4 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer

Office on Women's Health (OWH)

Living Healthier, Living Longer

-
- Less than 6 fl oz (3/4 cup)
 - 8 fl oz (1 cup)
 - 12 fl oz (1 1/2 cups)
 - 16 fl oz (2 cups)
 - More than 20 fl oz (2 1/2 cups)
-

32. During the past month, how often did you drink coffee or tea with sugar or honey added? Do not include drinks with things like Splenda or Equal. Include pre-sweetened tea and coffee drinks such as Arizona Iced Tea and Frappuccino.

- _____ times per:
- Day
 - Week
 - Month³
 - Never (*skip to question 34*)
 - Don't know (*skip to question 34*)
-

33. Each time you drank sweetened tea or coffee, how much did you usually drink?

- Less than 6 fl oz (3/4 cup)
 - 8 fl oz (1 cup)
 - 12 fl oz (1 1/2 cups)
 - 16 fl oz (2 cups)
 - More than 20 fl oz (2 1/2 cups)
-

34. In the past month, how often did you drink water (including tap, bottled, and carbonated water)?

- _____ times per:
- Day
 - Week
 - Month
 - Never (*skip to question 36*)
 - Don't know (*skip to question 36*)
-

35. Each time you drank water, how much did you usually drink?

- Less than 6 fl oz (3/4 cup)
- 8 fl oz (1 cup)
- 12 fl oz (1 1/2 cups)
- 16 fl oz (2 cups)
- More than 20 fl oz (2 1/2 cups)

Office on Women's Health (OWH)

Living Healthier, Living Longer

For alcohol, a drink is equal to half an ounce of absolute alcohol (e.g. a 12 ounce can or glass of beer or cooler, a 5 ounce glass of wine, or a drink containing 1 shot of liquor).

36. During the last 30 days, how often did you usually have any kind of drink containing alcohol? Choose only one.

- Every day
 - 5 to 6 times a week
 - 3 to 4 times a week
 - twice a week
 - once a week
 - 2 to 3 times a month
 - once a month
 - I did not drink any alcohol in the past month, but I did drink in the past (*done with survey*)
 - I never drank any alcohol in my life (*done with survey*)
-

37. During the last 30 days, how many alcoholic drinks did you have on a typical day when you drank alcohol?

- 25 or more drinks
 - 19 to 24 drinks
 - 16 to 18 drinks
 - 12 to 15 drinks
 - 9 to 11 drinks
 - 7 to 8 drinks
 - 5 to 6 drinks
 - 3 to 4 drinks
 - 2 drinks
 - 1 drink
-

38. During the last 30 days, how often did you have 4 or more drinks containing any kind of alcohol in within a two-hour period? Choose only one.

- Every day
 - 5 to 6 days a week
 - 3 to 4 days a week
 - two days a week
-

Office on Women's Health (OWH)

Living Healthier, Living Longer

-
- one day a week
 - 2 to 3 days a month
 - one day a month
-

End of Questionnaire