

# Your Program Name

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## *Participant Information Survey*

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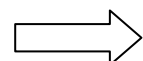
Participant I.D. (first two letters of your first name, first two letters of your last name, last two numbers of your birth year): \_ \_ \_ \_ \_

1. How old are you today? \_\_\_\_\_ years
2. Are you:  Male or  Female?
3. Are you of Hispanic, Latino, or Spanish origin?  
 Yes             No
4. 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
5. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)

<input type="radio"/> Arthritis/Rheumatic Disease	<input type="radio"/> Hypertension (High Blood Sugar)
<input type="radio"/> Asthma/Emphysema/Other Chronic Breathing or Lung Problem	<input type="radio"/> Kidney Disease
<input type="radio"/> Cancer or Cancer Survivor	<input type="radio"/> Osteoporosis (Low Bone Density)
<input type="radio"/> Chronic Pain	<input type="radio"/> Obesity
<input type="radio"/> Depression or Anxiety Disorders	<input type="radio"/> Schizophrenia or Other Psychotic Disorder
<input type="radio"/> Diabetes (High Blood Sugar)	<input type="radio"/> Stroke
<input type="radio"/> Heart Disease	<input type="radio"/> Other Chronic Condition
<input type="radio"/> High Cholesterol	<input type="radio"/> None (No Chronic Conditions)

6. 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

**Please turn over**



7. Are you deaf or do you have serious difficulty hearing?  
 Yes  No
8. Are you blind or do you have serious difficulty seeing even with glasses?  
 Yes  No
9. Because of a physical, mental, or emotional condition, do you have serious difficulty walking or climbing stairs, dressing or bathing, or doing errands alone such as visiting a doctor's office or shopping?  
 Yes  No
10. Do you live alone?  Yes  No
11. 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
12. In general, would you say that your health is:
- Excellent  Very good  Good  Fair  Poor
13. Did your doctor or other health care provider suggest that you take this program?  
 Yes  No

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TO BE COMPLETED AT LAST PROGRAM SESSION

*Please circle the number that best matches how confident you are feeling.*

14. After taking this workshop, I am more confident that I can manage my chronic condition(s).

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