# Your Program Name

## *Participant Information Survey*

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: O Male or O Female?

3. Are you of Hispanic, Latino, or Spanish origin?
   O Yes O No

4. What is your race? Mark all that apply.

   O American Indian or Alaska Native
   O Asian
   O Black or African American
   O Native Hawaiian or other Pacific Islander
   O White

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

| | |
|---|---|
| O Arthritis/Rheumatic Disease | O Hypertension (High Blood Sugar) |
| O Asthma/Emphysema/Other Chronic Breathing or Lung Problem | O Kidney Disease |
| O Cancer or Cancer Survivor | O Osteoporosis (Low Bone Density) |
| O Chronic Pain | O Obesity |
| O Depression or Anxiety Disorders | O Schizophrenia or Other Psychotic Disorder |
| O Diabetes (High Blood Sugar) | O Stroke |
| O Heart Disease | O Other Chronic Condition |
| O High Cholesterol | O 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?

   O Yes O No

**Please turn over**

7. Are you deaf or do you have serious difficulty hearing?
   O Yes O No

8. Are you blind or do you have serious difficulty seeing even with glasses?
   O Yes O 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?
   O Yes O No

10. Do you live alone? O Yes O No

11. What is the highest grade or year of school you completed?
   O Some elementary, middle, or high school
   O High school graduate or GED
   O Some college or technical school
   O College 4 years or more

12. In general, would you say that your health is:

O Excellent O Very good O Good O Fair O Poor

13. Did your doctor or other health care provider suggest that you take this program?
   O Yes O 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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