Form Approved

OMB No. 0920-XXXX

Exp. Date: XX/XX/XXXX

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| --- |
| Centers for Disease Control and Prevention |
| Chronic Disease Self-Management Questionnaire |
| Adapted from the Stanford Patient Education Research Center and the Ke Ola Pono Program, Hawaii Healthy Aging Partnership. |

**Please fill out this survey and return to your CDSMP leader.**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**BACKGROUND**

1. What chronic conditions do you have? (check all that apply)

|  |  |
| --- | --- |
| Arthritis | Diabetes |
| Asthma | Heart Disease |
| Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | High Blood Pressure |
| Chronic bronchitis, emphysema, or COPD | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. What is your age?

18-29  30-39  40-49  50-59  60-69  70-79  80 and over

1. Please check one or more of the following that best defines your race and/or ethnicity:

|  |  |  |
| --- | --- | --- |
| American Indian/Alaska Native | Hispanic/Latino | ☐ Samoan |
| Black/African American | Japanese | ☐ Tongan |
| Carolinian | Marshallese | ☐ White |
| Chamorro | ☐ Micronesian | ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Chinese | ☐ Native Hawaiian |  |
| Filipino | ☐ Palauan |  |

1. What is the highest level of education you have completed (check one):

|  |  |
| --- | --- |
| Less than high school | Some college or vocational school |
| Some high school | College graduate |
| High school graduate | Graduate school |

1. What language(s) do you speak at home (check all that apply):

|  |  |  |  |
| --- | --- | --- | --- |
| Carolinian | English | Palauan | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Chamorro | Japanese | Pohnpeian |  |
| Chinese | Kosraean | Samoan |  |
| Chuukese | Marshallese | Tagalog |  |

1. Are you currently married or living as married?

Yes  No

1. In general, would you say your health is (circle one): Excellent Very Good Good Fair Poor

**GENERAL HEALTH**

**PHYSICAL ACTIVITIES**

|  |  |
| --- | --- |
| 1. **During the past week**, other than your regular job, did you participate in any physical activity or exercise, such as brisk walking, running, dancing, biking, water exercise, etc.? | Yes  No |
| 1. How many **days in the past week** were you physically active for at least 30 minutes that may cause faster breathing or heartbeat, or feeling warmer (it does not have to be at one time)? | \_\_\_\_\_\_\_\_\_\_\_ days / past week |
| 1. **How many days in the past week** did you do stretching or strengthening exercises, such as range of motion, using weights/resistance, yoga, tai chi, pilates, etc.? | \_\_\_\_\_\_\_\_\_ days / past week |

**DAILY ACTIVITIES**

During the **past week**, how much has your health interfered with: (circle one number for each question)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Not at all | Slightly | Moderately | Quite a bit | Almost totally |
| 1. Normal activities with family, friends, neighbors and groups? | 0 | 1 | 2 | 3 | 4 |
| 1. Hobbies or recreational activities? | 0 | 1 | 2 | 3 | 4 |
| 1. Household chores? | 0 | 1 | 2 | 3 | 4 |
| 1. Errands and shopping? | 0 | 1 | 2 | 3 | 4 |

**SYMPTOMS**

1. Please circle the number below that describes your **fatigue (feeling tired)** in the **past week**:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | http://patienteducation.stanford.edu/images/bar00.gif | http://patienteducation.stanford.edu/images/bar01.gif | http://patienteducation.stanford.edu/images/bar02.gif | http://patienteducation.stanford.edu/images/bar03.gif | http://patienteducation.stanford.edu/images/bar04.gif | http://patienteducation.stanford.edu/images/bar05.gif | http://patienteducation.stanford.edu/images/bar06.gif | http://patienteducation.stanford.edu/images/bar07.gif | http://patienteducation.stanford.edu/images/bar08.gif | http://patienteducation.stanford.edu/images/bar09.gif | http://patienteducation.stanford.edu/images/bar10.gif |  |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |  |

No fatigue Severe

fatigue

1. Please circle the number below that describes your **pain** in the **past week**:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | http://patienteducation.stanford.edu/images/bar00.gif | http://patienteducation.stanford.edu/images/bar01.gif | http://patienteducation.stanford.edu/images/bar02.gif | http://patienteducation.stanford.edu/images/bar03.gif | http://patienteducation.stanford.edu/images/bar04.gif | http://patienteducation.stanford.edu/images/bar05.gif | http://patienteducation.stanford.edu/images/bar06.gif | http://patienteducation.stanford.edu/images/bar07.gif | http://patienteducation.stanford.edu/images/bar08.gif | http://patienteducation.stanford.edu/images/bar09.gif | http://patienteducation.stanford.edu/images/bar10.gif |  |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |  |

No pain Severe

pain

1. Please circle the number below that describes your **shortness of breath** in the **past week**:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | http://patienteducation.stanford.edu/images/bar00.gif | http://patienteducation.stanford.edu/images/bar01.gif | http://patienteducation.stanford.edu/images/bar02.gif | http://patienteducation.stanford.edu/images/bar03.gif | http://patienteducation.stanford.edu/images/bar04.gif | http://patienteducation.stanford.edu/images/bar05.gif | http://patienteducation.stanford.edu/images/bar06.gif | http://patienteducation.stanford.edu/images/bar07.gif | http://patienteducation.stanford.edu/images/bar08.gif | http://patienteducation.stanford.edu/images/bar09.gif | http://patienteducation.stanford.edu/images/bar10.gif |  |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |  |

No shortness Severe

of breath shortness

of breath

1. Please circle the number below that describes your **stress** in the **past week**:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | http://patienteducation.stanford.edu/images/bar00.gif | http://patienteducation.stanford.edu/images/bar01.gif | http://patienteducation.stanford.edu/images/bar02.gif | http://patienteducation.stanford.edu/images/bar03.gif | http://patienteducation.stanford.edu/images/bar04.gif | http://patienteducation.stanford.edu/images/bar05.gif | http://patienteducation.stanford.edu/images/bar06.gif | http://patienteducation.stanford.edu/images/bar07.gif | http://patienteducation.stanford.edu/images/bar08.gif | http://patienteducation.stanford.edu/images/bar09.gif | http://patienteducation.stanford.edu/images/bar10.gif |  |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |  |

No stress Severe

stress

1. Please circle the number below that describes your **sleep** in the **past week**:

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | http://patienteducation.stanford.edu/images/bar00.gif | http://patienteducation.stanford.edu/images/bar01.gif | http://patienteducation.stanford.edu/images/bar02.gif | http://patienteducation.stanford.edu/images/bar03.gif | http://patienteducation.stanford.edu/images/bar04.gif | http://patienteducation.stanford.edu/images/bar05.gif | http://patienteducation.stanford.edu/images/bar06.gif | http://patienteducation.stanford.edu/images/bar07.gif | http://patienteducation.stanford.edu/images/bar08.gif | http://patienteducation.stanford.edu/images/bar09.gif | http://patienteducation.stanford.edu/images/bar10.gif |  |
|  | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |  |

No sleep Severe

Problems sleep

Problems

**CONFIDENCE ABOUT DOING THINGS**

For each of the following questions, please circle the number that corresponds to your confidence that you can do the tasks regularly at the present time.

|  |  |
| --- | --- |
| 1. How confident are you that you can keep the **fatigue (tiredness)** caused by your disease from interfering with the things you want to do? | Not at all 1 2 3 4 5 6 7 8 9 10 Totally  confident confident |
| 1. How confident are you that you can keep the **physical discomfort or pain** of your disease from interfering with the things you want to do? | Not at all 1 2 3 4 5 6 7 8 9 10 Totally  confident confident |
| 1. How confident are you that you can keep **emotional distress** caused by your disease from interfering with the things you want to do? | Not at all 1 2 3 4 5 6 7 8 9 10 Totally  confident confident |
| 1. How confident are you that you can keep any **other symptoms or health problems** you have from interfering with the things you want to do? | Not at all 1 2 3 4 5 6 7 8 9 10 Totally  confident confident |
| 1. How confident are you that you can **do the different tasks and activities** needed to manage your health conditions so as to reduce your need to see a doctor? | Not at all 1 2 3 4 5 6 7 8 9 10 Totally  confident confident |
| 1. How confident are you that you can **do things other than just taking medication** to reduce how much your illness affects your everyday life? | Not at all 1 2 3 4 5 6 7 8 9 10 Totally  confident confident |

**COPING WITH SYMPTOMS**

**When you are feeling down in the dumps, feeling pain, or having other unpleasant symptoms, how**

**often do you do the following:** (please circle one number for each question)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Never** | **Almost Never** | **Some-times** | **Fairly Often** | **Very Often** | **Always** |
| 1. Try to feel distant form the discomfort and pretend that it is not part of your body? | 0 | 1 | 2 | 3 | 4 | 5 |
| 1. Don't think of it as discomfort but as some other sensation, like a warm, numb feeling? | 0 | 1 | 2 | 3 | 4 | 5 |
| 1. Play mental games or sing songs to keep your mind off of the discomfort? | 0 | 1 | 2 | 3 | 4 | 5 |
| 1. Practice progressive muscle relaxation? | 0 | 1 | 2 | 3 | 4 | 5 |
| 1. Practice visualization or guided imagery, such as picturing yourself somewhere else? | 0 | 1 | 2 | 3 | 4 | 5 |
| 1. Talk to yourself in a positive way. | 0 | 1 | 2 | 3 | 4 | 5 |

**MEDICAL CARE**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1. When you visit your doctor, how often do you do the following (circle one number for each question): | | | | | | | |
|  | Never | Almost  never | Some-  times | Fairly often | | Very often | Always |
| 1. Prepare a list of questions for your health care provider | 0 | 1 | 2 | 3 | | 4 | 5 |
| 1. Ask questions about the things you want to know and things you don’t understand about your treatment | 0 | 1 | 2 | 3 | | 4 | 5 |
| 1. Discuss any personal problems that may be related to your illness | 0 | 1 | 2 | 3 | | 4 | 5 |
| 1. In the past 6 months, how many times did you visit a health care provider (do not count visits while in the hospital or the hospital emergency department) | | | | | \_\_\_\_\_\_\_\_\_\_\_ visits | | |
| 1. In the past 6 months, how many times did you go to a hospital emergency department? | | | | | \_\_\_\_\_\_\_\_\_\_\_ times | | |
| 1. In the past 6 months, how many TIMES were you hospitalized for one night or longer? | | | | | \_\_\_\_\_\_\_\_\_\_\_ times | | |

**MEDICINES**

|  |  |
| --- | --- |
| 1. Do you ever forget to take your medicine? | Yes  No |
| 1. Do you ever have problems remembering to take your medicine? | Yes  No |
| 1. When you feel better, do you sometimes stop taking your medicine? | Yes  No |
| 1. Sometimes, if you feel worse when you take your medicine, do you stop taking it? | Yes  No |

**THANK YOU FOR YOUR HELP!**