Form Approved
OMB No. 0920-XXXX
Exp. Date: XX/XX/XXXX

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.

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

☐ Arthritis
☐ Asthma
☐ Cancer: _____
☐ Chronic bronchitis, emphysema, or COPD
☐ Diabetes
☐ Heart Disease
☐ High Blood Pressure
☐ Other: _____

2. What is your age?

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

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

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

BACKGROUND

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

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

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

☐ Carolinian
☐ Chamorro
☐ Chinese
☐ Chuukese
☐ English
☐ Japanese
☐ Kosraean
☐ Marshallese
☐ Palauan
☐ Pohnpeian
☐ Samoan
☐ Tagalog
☐ Other: _____

6. Are you currently married or living as married?

☐ Yes ☐ No

GENERAL HEALTH

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

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
2. 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
3. **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

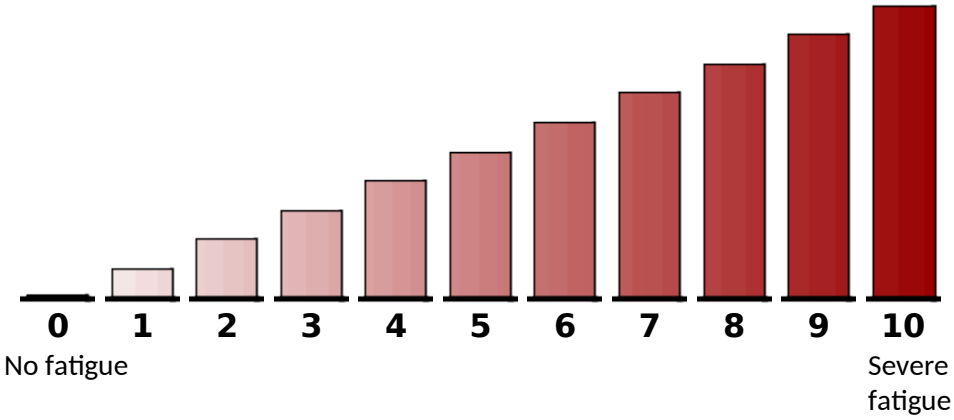
DAILY ACTIVITIES

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

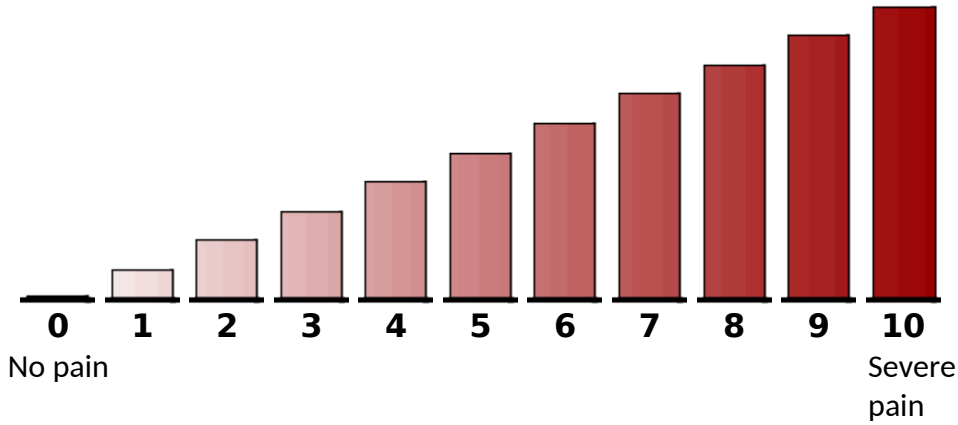
	Not at all	Slightly	Moderately	Quite a bit	Almost totally
1. Normal activities with family, friends, neighbors and groups?	0	1	2	3	4
2. Hobbies or recreational activities?	0	1	2	3	4
3. Household chores?	0	1	2	3	4
4. Errands and shopping?	0	1	2	3	4

SYMPTOMS

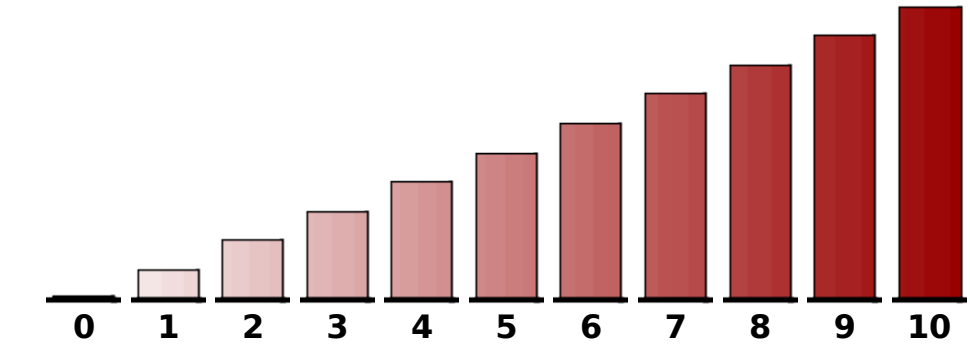
1. Please circle the number below that describes your **fatigue (feeling tired)** in the **past week**:



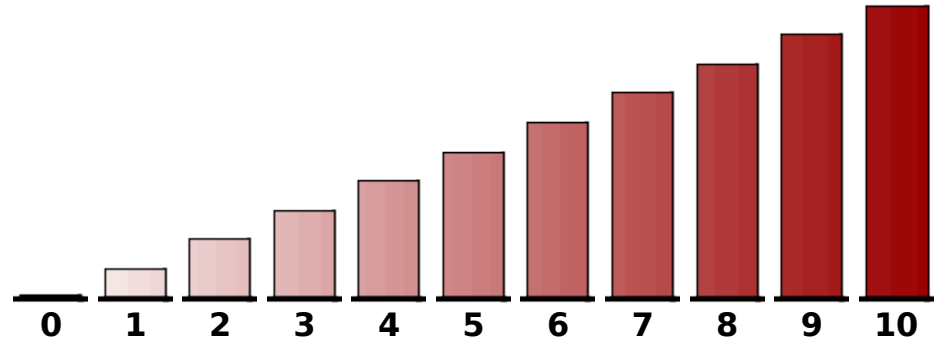
2. Please circle the number below that describes your **pain** in the **past week**:



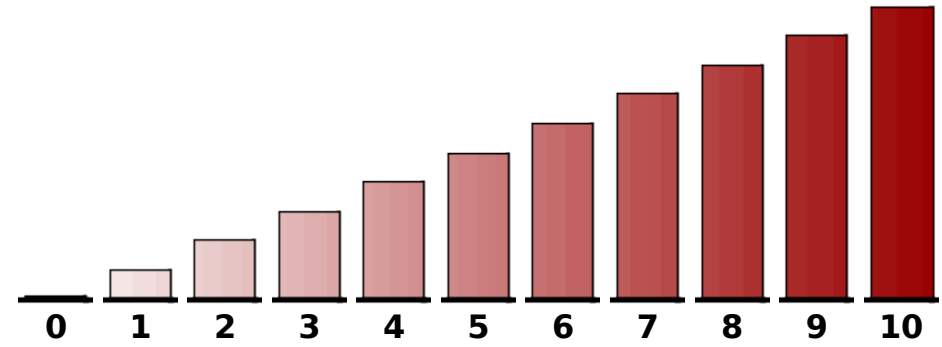
3. Please circle the number below that describes your **shortness of breath** in the **past week**:



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



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



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 confident	1	2	3	4	5	6	7	8	9	10	Totally confident
2. 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 confident	1	2	3	4	5	6	7	8	9	10	Totally confident
3. 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 confident	1	2	3	4	5	6	7	8	9	10	Totally confident
4. 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 confident	1	2	3	4	5	6	7	8	9	10	Totally confident
5. 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 confident	1	2	3	4	5	6	7	8	9	10	Totally confident
6. 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 confident	1	2	3	4	5	6	7	8	9	10	Totally 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
2. Don't think of it as discomfort but as some other sensation, like a warm, numb feeling?	0	1	2	3	4	5
3. Play mental games or sing songs to keep your mind off of the discomfort?	0	1	2	3	4	5

4. Practice progressive muscle relaxation?	0	1	2	3	4	5
5. Practice visualization or guided imagery, such as picturing yourself somewhere else?	0	1	2	3	4	5
6. 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
a. Prepare a list of questions for your health care provider	0	1	2	3	4	5
b. Ask questions about the things you want to know and things you don't understand about your treatment	0	1	2	3	4	5
c. Discuss any personal problems that may be related to your illness	0	1	2	3	4	5

2. 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

3. In the past 6 months, how many times did you go to a hospital emergency department? _____ times

4. 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

2. Do you ever have problems remembering to take your medicine? ☐ Yes ☐ No

3. When you feel better, do you sometimes stop taking your medicine? ☐ Yes ☐ No

4. Sometimes, if you feel worse when you take your medicine, do you stop taking it? ☐ Yes ☐ No

THANK YOU FOR YOUR HELP!