Program Name

Participant Information Survey

Admin Use Only: ***Participant I.D.:*** The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.
State abbreviation: __ __ (e.g., NY, VA, etc.)
First four letters of the site name: __ __ __ __
Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/19)
Participant number: __ __ (e.g., 01, 02, 03, etc.)

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1. Did your doctor or other health care provider suggest that you take this program?
   O Yes O No

2. How old are you today? _____ years

3. Are you: O Male or O Female?

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

5. 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

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

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

8. Do you live alone? O Yes O No

9. 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

10. Have you ever served in the military?
    O Yes O No

11. 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

12. For whom are you attending this program?
O Myself O Accompanying someone else O Both

13. In general, would you say that your health is:
O Excellent O Very good O Good O Fair O Poor

14. Has a health care provider ever told you that you have any of the following chronic conditions?

	YES	NO		YES	NO
Anxiety Disorder			Chronic Pain		
High Cholesterol			Kidney Disease		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Obesity		
Hypertension (High Blood Pressure)			Schizophrenia or Other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Arthritis/Rheumatic Disease		
Heart Disease			Other Chronic Condition		

15. Because of a physical, mental, or emotional condition, do you:
- Have serious difficulty walking or climbing stairs? O Yes O No
- Have difficulty dressing or bathing? O Yes O No
- Have difficulty doing errands alone such as visiting a doctor's office or shopping? O Yes O No

16. How often do you feel lonely or isolated from those around you?
O Always O Often O Sometimes O Rarely O Never

17. How confident are you that you can manage your chronic condition(s).

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

TO BE COMPLETED AT LAST PROGRAM SESSION

Admin Use Only:

Participant I.D.: The facilitator or program staff should complete this part of the form and mark the sequential number of the participant to the name on the attendance form.

State abbreviation: __ __ (e.g., NY, VA, MA, etc.)

First four letters of the site name: __ __ __ __

Start date of program: __ __ / __ __ / __ __ (e.g., 12 01 19)

Participant number: __ __ (e.g., 01, 02, 03, etc.)

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

O Excellent O Very good O Good O Fair O Poor

2. How confident are you that you can manage your chronic condition(s).

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

3. How often do you feel lonely or isolated from those around you?

O Always O Often O Sometimes O Rarely O Never