OMB Control No. 0985-0036
Exp. Date XX/XX/20XX

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.)

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

2. How old are you today?_____ years

3. Do you live alone? ☐ Yes ☐ No

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

5. What is your race? **Check all that apply.**
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Some other race (please specify) _____

6. What is your current gender (**select one**)?
   - ☐ Man
   - ☐ Woman
   - ☐ Non-binary
   - ☐ _____ (please specify)
   - ☐ Prefer not to answer

7. Do you consider yourself to be transgender?
   - ☐ Yes ☐ No ☐ Prefer not to answer

8. Which of the following best represents how you think of yourself? [**Select ONE**]:
   - ☐ Lesbian or gay
   - ☐ Straight, that is, not gay or lesbian
   - ☐ Bisexual
   - ☐ [If respondent is AIAN:] Two-Spirit
   - ☐ I use a different term (please specify): _____
   - ☐ Don't know
   - ☐ Prefer not to answer

9. What is the highest grade or year of school you completed?

☐ Some elementary, middle, or high school	☐ Some college of technical school
☐ High school graduate or GED	☐ College (4 years or more)

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

12. In general, would you say that your health is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

13. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)? **Please use an X to indicate your response Yes or No**

	YES	NO		YES	NO
Alzheimer's Disease or other Dementia			Kidney Disease		
Anxiety Disorder			Malnutrition		
Arthritis/Rheumatic Disease			Obesity		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Post-Traumatic Stress Disorder		
Chronic Pain			Schizophrenia or other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Substance Use Disorder		
Heart Disease			Urinary Incontinence		
High Cholesterol			Other Chronic Condition		
Hypertension (High Blood Pressure)					

14. Please use an **X** to indicate your response to the following questions.

	YES	NO
a. Are you deaf or do you have serious difficulty hearing?		
b. Are you blind or do you have serious difficulty seeing, even when wearing glasses?		
c. Do you have serious difficulty walking or climbing stairs?		
d. Do you have difficulty dressing or bathing?		
e. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?		
f. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?		

15. How often do you feel lonely?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

16. How often do you feel isolated from those around you?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

17. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure 1 2 3 4 5 6 7 8 9 10 Totally sure

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TO BE COMPLETED AT LAST PROGRAM SESSION

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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:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure 1 2 3 4 5 6 7 8 9 10 Totally sure

3. How often do you feel lonely?
☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

4. How often do you feel isolated from those around you?
☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

5. Since this program began, what have you done to manage your chronic condition(s)? **Check all that apply**
   - ☐ Talked to a family member or friend about my health
   - ☐ Talked to a healthcare provider about how I can better manage my chronic condition
   - ☐ Had my medications reviewed by a healthcare provider or pharmacist
   - ☐ Started or continued to exercise
   - ☐ Made changes to how I choose the food I eat
   - ☐ Participate in or plan to participate in another health-related or exercise program in my community

6. How would you rate your overall satisfaction with the quality of the program?
☐ Very Dissatisfied ☐ Dissatisfied ☐ Okay ☐ Satisfied ☐ Very Satisfied