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?

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

15. Because of a physical, mental, or emotional condition, do you:
   o Have serious difficulty walking or climbing stairs?  O Yes     O No
   o Have difficulty dressing or bathing?  O Yes     O No
   o 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
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