1. Did your doctor or other health care provider suggest that you attend 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 when wearing 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. In general, would you say that your health is:
   O Excellent      O Very good      O Good      O Fair      O Poor

13. 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>Chronic Pain</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td></td>
<td>Kidney Disease</td>
</tr>
<tr>
<td>Asthma/Emphysema/Other Chronic Breathing or Lung Problem</td>
<td></td>
<td>Osteoporosis (Low Bone Density)</td>
</tr>
<tr>
<td>Cancer or Cancer Survivor</td>
<td></td>
<td>Obesity</td>
</tr>
<tr>
<td>Hypertension (High Blood Pressure)</td>
<td></td>
<td>Schizophrenia or Other Psychotic Disorder</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>Stroke</td>
</tr>
<tr>
<td>Diabetes (High Blood Sugar)</td>
<td></td>
<td>Arthritis/Rheumatic Disease</td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td>Other Chronic Condition</td>
</tr>
</tbody>
</table>

14. Because of a physical, mental, or emotional condition, do you:
   o Have serious difficulty concentrating, remembering, or making decisions?
     O Yes      O No
   o Have difficulty doing errands alone such as visiting a doctor’s office or shopping?
     O Yes      O No

15. Do you have serious difficulty walking or climbing stairs?   O Yes      O No

16. Do you have difficulty dressing or bathing?   O Yes      O No

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

18. 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
1. In general, would you say that your health is:
   O Excellent               O Very good               O Good               O Fair               O 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 or isolated from those around you?
   O Always               O Often               O Sometimes               O Rarely               O Never