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?
   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

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

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Totally sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totally unsure</td>
<td></td>
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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.

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

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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?

<table>
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<th>Totally unsure</th>
<th>1</th>
<th>2</th>
<th>3</th>
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<th>5</th>
<th>6</th>
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3. How often do you feel lonely or isolated from those around you?
   - O Always
   - O Often
   - O Sometimes
   - O Rarely
   - O Never

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