



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: AL

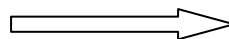
First four letters of the site name: _____

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. Are you: Male or Female?
 4. Are you of Hispanic, Latino, or Spanish origin? Yes No
 5. What is your race? Mark all that apply.
 - American Indian or Alaska Native
 - Asian
 - Black or African American
 - Native Hawaiian or other Pacific Islander
 - White
 6. Are you deaf or do you have serious difficulty hearing? Yes No
 7. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
 Yes No
 8. Do you live alone? Yes No

Please Turn Over



PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0985-0036. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Administration for Community Living, 330 C Street SW, Washington, D.C. 20201, Attention: PRA Reports Clearance Officer.

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

- Some elementary, middle, or high school
- High school graduate or GED
- Some college or technical school
- 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?

| | 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 | | |

14. Because of a physical, mental, or emotional condition, do you:

- Have serious difficulty concentrating, remembering, or making decisions?
 Yes No

- Have difficulty doing errands alone such as visiting a doctor's office or shopping?
 Yes No

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

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

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

Always Often Sometimes Rarely 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

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TO BE COMPLETED AT LAST PROGRAM SESSION

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State abbreviation: AL

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 or isolated from those around you?

Always Often Sometimes Rarely Never

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