Living Well

Participant Information Sheet

OMB Control No. 0985-0036
Exp. Date 11/22/2022

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.)

Instructions: Please use a pen to answer the questions on both sides of this form and print clearly. This information is optional and will help program funders learn if this program is reaching diverse populations and helping people with chronic conditions.

I understand that filling out this form is entirely voluntary.

NAME (optional): _____
What is your zip code? ____ ____ ____ ____ ____
What county do you live in? _____ (Douglas, Lancaster, Hall, etc)

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

2. How old are you today? _____ years

3. Are you: ☐ Male ☐ 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 ☐ Native Hawaiian or other Pacific Islander
☐ Asian ☐ White
☐ Black or African American

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 with wearing glasses?
☐ Yes ☐ No

8. Do you live alone?
☐ Yes ☐ No

9. What is the highest grade or year of school you completed?
☐ Some elementary, middle, or high school ☐ Some college or 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? (Please mark all that apply.)

	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

17. How often do you feel lonely or isolated form 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

19. Please indicate what type(s) of healthcare coverage you utilize:

☐ Medicare ☐ Medicaid ☐ No insurance

☐ Private Insurance ☐ Veteran's Affairs ☐ Other: _____