



Living Healthy & Living Healthy with Diabetes



Participant Information Survey

Instructions:

Please use a pen to answer the questions on both sides of this form.
Please print clearly. Mark your choice within the box, like this:

Your Name: _____

1. What is your date of birth?

		/			/				
Month			Day			Year			

2. What is your gender?

- Female
- Male

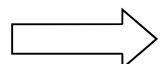
3. Are you of Hispanic, Latino, or Spanish origin?

- Yes
- No
- Unknown

4. What is your race? (Mark all that apply.)

- American Indian or Alaska Native
- Asian or Asian-American
- Black or African-American
- Hawaiian Native or Pacific Islander
- White or Caucasian
- Other: _____

Please turn over



Participant Information Survey—continued

Your Name: _____

5. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)

- Arthritis/ Rheumatic Disease**
- Breathing/ Lung Disease (e.g., Asthma, Emphysema, Bronchitis)**
- Cancer**
- Depression or Anxiety Disorders**
- Diabetes**
- Heart Disease**
- Hypertension (High Blood Pressure)**
- Stroke**
- Osteoporosis (Low Bone Density)**
- Other Chronic Condition:** _____
- None (No Chronic Conditions)**

6. What is your Zip Code?

7. Today, how many people live in your household (including yourself)? (Number of people)

8. Have you ever taken THIS chronic disease self-management workshop before?

- Yes**
- No**
- Unsure**

9. How did you hear about this class?

- Church / Faith-based group
- Newspaper ad/article
- Friend / Family
- Sr. center announcement
- Flyer / poster
- Healthcare provider
- UHC / AARP
- Other _____

~ **THANK YOU!** ~