Your Program Name

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: [X]

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 a chronic disease self-management workshop before?

- ☐ **Yes**
- ☐ **No**
- ☐ **Unsure**

Thank you!