Walk With Ease Participant Information Form

Your Name: __________________________________________________

1. How old are you today? ______ years

2. Are you: O Male or O Female?

3. Are you of Hispanic, Latino, or Spanish origin?
   O Yes  O No

4. 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

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

<table>
<thead>
<tr>
<th>O Arthritis/Rheumatic Disease</th>
<th>O Hypertension (High Blood Pressure)</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Asthma/Emphysema/Other Chronic Breathing or Lung Problem</td>
<td>O Kidney Disease</td>
</tr>
<tr>
<td>O Cancer or Cancer Survivor</td>
<td>O Osteoporosis (Low Bone Density)</td>
</tr>
<tr>
<td>O Chronic Pain</td>
<td>O Obesity</td>
</tr>
<tr>
<td>O Depression or Anxiety Disorders</td>
<td>O Schizophrenia or Other Psychotic Disorder</td>
</tr>
<tr>
<td>O Diabetes (High Blood Sugar)</td>
<td>O Stroke</td>
</tr>
<tr>
<td>O Heart Disease</td>
<td>O Other Chronic Condition</td>
</tr>
<tr>
<td>O High Cholesterol</td>
<td>O None (No Chronic Conditions)</td>
</tr>
</tbody>
</table>

**** CONTINUED ON NEXT PAGE ****
6. 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

7. Are you deaf or do you have serious difficulty hearing?
   O Yes      O No

8. Are you blind or do you have serious difficulty seeing even with glasses?
   O Yes      O No

9. Because of a physical, mental, or emotional condition, do you have serious difficulty walking or climbing stairs, dressing or bathing, or doing errands alone such as visiting a doctor’s office or shopping?
   O Yes      O No

10. Do you live alone?
    O Yes      O No

11. 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

12. In general, would you say that your health is:
    O Excellent      O Very good      O Good      O Fair      O Poor

13. Did your doctor or other health care provider suggest that you take this program?
    O Yes      O No
    If you responded no, please tell us how you found out about the program.

_____________________________________________________________________

**** CONTINUED ON NEXT PAGE ****
14. How confident are you in managing your arthritis symptoms? (Circle one number)

Not at all confident

<table>
<thead>
<tr>
<th>0</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>
</tr>
</thead>
</table>

Very confident

15. How many days during the week do you go for a walk/s?

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5
- ○ 6
- ○ 7

16. On average, how many minutes do you walk on each of those days?

__________

THANK YOU FOR COMPLETING THIS INFORMATION FORM!