

# Walk With Ease Participant Information Form

Your Name: \_\_\_\_\_

1. How old are you today? \_\_\_\_\_ years
  
2. Are you:  Male or  Female?
  
3. Are you of Hispanic, Latino, or Spanish origin?  
 Yes       No
  
4. 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

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

<input type="radio"/> Arthritis/Rheumatic Disease	<input type="radio"/> Hypertension (High Blood Pressure)
<input type="radio"/> Asthma/Emphysema/Other Chronic Breathing or Lung Problem	<input type="radio"/> Kidney Disease
<input type="radio"/> Cancer or Cancer Survivor	<input type="radio"/> Osteoporosis (Low Bone Density)
<input type="radio"/> Chronic Pain	<input type="radio"/> Obesity
<input type="radio"/> Depression or Anxiety Disorders	<input type="radio"/> Schizophrenia or Other Psychotic Disorder
<input type="radio"/> Diabetes (High Blood Sugar)	<input type="radio"/> Stroke
<input type="radio"/> Heart Disease	<input type="radio"/> Other Chronic Condition
<input type="radio"/> High Cholesterol	<input type="radio"/> None (No Chronic Conditions)

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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?

Yes       No

7. Are you deaf or do you have serious difficulty hearing?

Yes       No

8. Are you blind or do you have serious difficulty seeing even with glasses?

Yes       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?

Yes       No

10. Do you live alone?

Yes       No

11. 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

12. In general, would you say that your health is:

Excellent       Very good       Good       Fair       Poor

13. Did your doctor or other health care provider suggest that you take this program?

Yes       No

If you responded no, please tell us how you found out about the program.

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14. How confident are you in managing your arthritis symptoms? (Circle one number)

Not at all  
confident

Very  
confident

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0    1    2    3    4    5    6    7    8    9    10

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!**