

# Walk with Ease

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## *Participant Information Survey*

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**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.)

1. Did your doctor or other health care provider suggest that you attend this program?      Yes      No
  
2. How old are you today? \_\_\_\_\_ years
  
3. Do you live alone?     Yes     No
  
4. Are you of Hispanic, Latino, or Spanish origin?      Yes      No
  
5. What is your race? **Check all that apply.**
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or other Pacific Islander
  - White
  - Some other race (please specify) \_\_\_\_\_
  
6. What is your current gender (**select one**)?
  - Man
  - Woman
  - Non-binary
  - \_\_\_\_\_(please specify)
  - Prefer not to answer
  
7. Do you consider yourself to be transgender?
  - Yes       No       Prefer not to answer
  
8. Which of the following best represents how you think of yourself? [**Select ONE**]:
  - Lesbian or gay
  - Straight, that is, not gay or lesbian
  - Bisexual
  - [If respondent is AIAN:] Two-Spirit
  - I use a different term (please specify): \_\_\_\_\_
  - Don't know
  - Prefer not to answer

9. What is the highest grade or year of school you completed?

<input type="checkbox"/> Some elementary, middle, or high school	<input type="checkbox"/> Some college of technical school
<input type="checkbox"/> High school graduate or GED	<input type="checkbox"/> 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 (i.e., one that has lasted for three months or more)? **Please use an X to indicate your response Yes or No**

	YES	NO		YES	NO
Alzheimer's Disease or other Dementia			Kidney Disease		
Anxiety Disorder			Malnutrition		
Arthritis/Rheumatic Disease			Obesity		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Post-Traumatic Stress Disorder		
Chronic Pain			Schizophrenia or other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Substance Use Disorder		
Heart Disease			Urinary Incontinence		
High Cholesterol			Other Chronic Condition		
Hypertension (High Blood Pressure)					

14. Please use an X to indicate your response to the following questions.

	YES	NO
a. Are you deaf or do you have serious difficulty hearing?		
b. Are you blind or do you have serious difficulty seeing, even when wearing glasses?		
c. Do you have serious difficulty walking or climbing stairs?		
d. Do you have difficulty dressing or bathing?		
e. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?		
f. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?		

15. How often do you feel lonely?

- Always     Often     Sometimes     Rarely     Never

16. How often do you feel isolated from those around you?

- Always     Often     Sometimes     Rarely     Never

17. 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

18. How many days do you go for a walk/s

- 0     1     2     3     4     5     6     7

19. How many minutes do you walk on each of those days? \_\_\_\_\_

**Public Burden Statement:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-0036). Public reporting burden for this collection of information is estimated to average .20 hours per response, including time for gathering and maintaining the data needed and completing and reviewing the collection of information. The obligation to respond to this collection is voluntary.