Take Control of Your Health

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 (***First Name Only***): _____

1. What is your date of birth? ☐☐ / ☐☐ / ☐☐☐☐
   Month *Day* *Year*

2. What is your zip code? ☐☐☐☐☐

3. What is your sex?

   ☐ Female ☐ Male

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

   ☐ Yes ☐ No ☐ Unknown

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

   ☐ American Indian or Alaska Native
   ☐ Asian or Asian-American
   ☐ Black or African-American
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ White

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

   ☐ Alzheimer's or Related Dementia
   ☐ Arthritis/Rheumatic Disease
   ☐ Breathing/Lung Disease (Asthma, Emphysema, Bronchitis, etc.)
   ☐ Cancer or Cancer Survivor
   ☐ Chronic Pain
   ☐ Depression or Anxiety Disorders
   ☐ Diabetes
   ☐ Heart Disease
   ☐ High Cholesterol
   ☐ Hypertension (High Blood Pressure)
   ☐ Multiple Sclerosis
   ☐ Osteoporosis (Low Bone Density)
   ☐ Stroke
   ☐ Other Chronic Condition: _____
   ☐ None (No Chronic Conditions)

Please turn over ⇨

Participant Information Survey (Continued)

Your Name (***First Name Only***): _____

7. 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

8. Are you limited in any way in any activities because of physical, mental or emotional problems?

   ☐ Yes ☐ No

9. Today, how many people live in your household (including yourself)? ☐☐

   (Number of people)

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

   ☐ Some elementary, middle or high school
   ☐ High school or GED
   ☐ Some college or technical school
   ☐ College 4 years or more