OMB Control No. 0985-0036
Exp. Date 10/31/2019

Colorado CDSME Collaborative

Participant Information Survey

Participant I.D. (first two letters of your first name, first two letters of your last name, last two numbers of your birth year): __ __ __ __ __ __

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

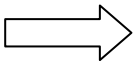
5. Has a health care provider ever told you that you have any of the following chronic conditions? (Please mark all that apply.)

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

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

Please turn over



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

TO BE COMPLETED AT LAST PROGRAM SESSION

Please circle the number that best matches how confident you are feeling.

14. After taking this workshop, I am more confident that I can manage my chronic condition(s).

Not at all confident	1	2	3	4	5	6	7	8	9	10	Totally confident