

Fit and Strong! Participant Pre-Survey

Participant Number or Name: _____

Workshop ID: _____ **Site Name:** _____

Start date of program: _____ / _____ / _____ (e.g., 05/01/23)

Program Name:

Fit and Strong!

1. How did you hear about this class?

- | | |
|--|---|
| <input type="checkbox"/> Physician or member of my healthcare team | <input type="checkbox"/> Health fair/ community event |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Congregate/ home delivered meal notification |
| <input type="checkbox"/> Community Organization | <input type="checkbox"/> Information Session/ presentation |
| <input type="checkbox"/> Care Coordinator | <input type="checkbox"/> Email |
| <input type="checkbox"/> Family member/friend | <input type="checkbox"/> Newsletter/ mass communication |
| <input type="checkbox"/> Flyer | <input type="checkbox"/> Print ad/ newspaper |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Radio/ pod cast |
| <input type="checkbox"/> Instagram | <input type="checkbox"/> Religious Institution |
| <input type="checkbox"/> Twitter | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Other social media | |

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.**

- | | |
|--|--|
| <input type="checkbox"/> Lesbian or gay | <input type="checkbox"/> I use a different term (please specify) _____ |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> Prefer not to answer |
| <input type="checkbox"/> [If respondent is AIAN:] Two-Spirit | |

IDPH Pre-Survey

Hello. Thank you for your participation in the Fit & Strong! program. As a class participant we are asking you to fill out this brief survey that will ask you questions about your general health and exercise habits. We ask you to complete this survey at the start and end of your Fit & Strong! class. This information is used to assess the impact the Fit & Strong! program is having on its participants.

Your name will NOT be attached to your survey, instead an anonymous ID will be used (e.g., Participant 01).

Your participation is voluntary. You may skip any questions you do not wish to answer.

If you have any questions about this survey, please ask your Fit & Strong! class instructor

Thank you!

1) Your Name/Identifier

(Note: Names will not be sent to the Fit & Strong! project team, only anonymous identifiers, like Participant 01).

2) Today's Date

3) Name of Organization Hosting this Class:

4) Name of Instructor(s) Leading this Class:

Please complete the questions below that asks about DEMOGRAPHIC INFORMATION. You can skip any questions you do not feel comfortable answering.

What choice best describes your gender?

- Female
 Male
 Other, specify below

If other, please specify

What is the highest grade or level of school you have completed?

- Never attended school or only attended kindergarten
 Grades 1 through 8 (Elementary)
 Grades 9 through 11 (Some High school)
 Grade 12 or GED (High school graduate)
 College 1 year to 3 years (Some college or technical school)
 College 4 years or more (College graduate)

What is your age?

Are you of Hispanic, Latino, or Spanish origin?

- Yes
 No

Which choice best describes your race or ethnicity?

- American Indian or Alaskan Native
 Non-Hispanic Black or African American
 White, not of Hispanic origin
 Asian
 Native Hawaiian or other Pacific Islander
 Other, please specify below

If Other, please describe

What is your height in feet___ and inches___?

What is your weight in pounds?

Do you live alone?

- Yes
 No

Which best describes your relationship status?

- Married
 Divorced
 Widowed
 Separated
 Never Married
 Domestic Partnership/member of an unmarried couple

Which best describes your current employment status?

- Employed for wages
- Self-employed
- Out of work for more than 1 year
- Out of work for less than 1 year
- Retired
- Homemaker
- Unable to work

What is your annual household income from all sources?

- \$0-\$9,999
- \$10,000-\$14,999
- \$15,000-\$19,999
- \$20,000-\$24,999
- \$25,000-\$34,999
- \$35,000-\$49,999
- \$50,000-\$74,999
- \$75,000+

Have you ever served in the military?

- Yes
- No

Please complete the questions below that asks about your GENERAL HEALTH. You can skip any questions you do not feel comfortable answering.

Did your doctor or healthcare provider suggest that you attend this program? Yes
 No

During the last 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

In general, how would you describe your health? Excellent
 Very Good
 Good
 Fair
 Poor

Has a healthcare 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 check all that apply.

- Alzheimer's Disease or other Dementia
- Anxiety Disorder
- Arthritis/Rheumatic Disease
- Asthma/Emphysema/Other
- Cancer or Cancer Survivor
- Chronic Breathing or Lung Problem
- Chronic Pain
- Depression
- Diabetes (high blood sugar)
- Heart Disease
- High Cholesterol
- Hypertension (high blood pressure)
- Kidney Disease
- Obesity
- Malnutrition
- Osteoporosis (low bone density)
- Post-Traumatic Stress Disorder
- Schizophrenia or other Psychotic Disorder
- Stroke
- Substance Use Disorder
- Urinary Incontinence
- Other Chronic Condition

If other, please describe

Please answer YES or NO to the following questions.

	Yes	No
Are you deaf or do you have serious hearing difficulty?	<input type="radio"/>	<input type="radio"/>
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	<input type="radio"/>	<input type="radio"/>
Do you have serious difficulty walking or climbing stairs?	<input type="radio"/>	<input type="radio"/>

Do you have difficulty dressing or bathing?

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

How often do you feel lonely? Always
 Often
 Sometimes
 Rarely
 Never

How often do you feel isolated from those around you? Always
 Often
 Sometimes
 Rarely
 Never

On a scale from 1-10, how sure are you that you can manage your condition so you can do the things you need or want to do? 1 being totally unsure and 10 being totally sure. 1 2 3 4
 5 6 7 8
 9 10

Please complete the questions below that asks about FALLS. You can skip any questions you do not feel comfortable answering.

In the past 3 months, have you fallen?

- No
 Yes

How many times?

If you fell in the last 3 months, how many of these falls caused an injury? (By injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor)

How fearful are you of falling?

- Not at All
 A Little
 Somewhat
 A Lot

During the last 4 weeks, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors, or groups?

- Extremely
 Quite a Bit
 Moderately
 Slightly
 Not at All

I have made safety modifications in my home, such as installing grab bars or securing loose rugs to reduce my risk of falling.

- True
 False

Please complete the survey below that asks about how often you feel the way described below. You can skip any questions that you do not feel comfortable answering.

39) How often do you feel a lack of companionship? Hardly ever/never
 Some of the time
 Often

40) How often do you feel left out? Hardly ever/never
 Some of the time
 Often

41) How often do you feel isolated from others? Hardly ever/never
 Some of the time
 Often

Please complete the survey below that asks about how often you feel the way described below. You can skip any questions that you do not feel comfortable answering.

During the past 7 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
42) I feel fatigued	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
43) I have trouble starting things because I am tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
44) How run-down did you feel on average?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
45) How fatigued were you on average?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In the past 7 days...

	Very poor	Poor	Fair	Good	Very good
46) My sleep quality was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

In the past 7 days...

	Not at all	A little bit	Somewhat	Quite a bit	Very much
47) My sleep was refreshing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
48) I had a problem with my sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
49) I had difficulty falling asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Ability to Participate in Social Roles and Activities

	Never	Rarely	Sometimes	Usually	Always
50) I have trouble doing all of my regular leisure activities with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
51) I have trouble doing all of the family activities that I want to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
52) I have trouble doing all of my usual work (include work at home)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
53) I have trouble doing all of the activities with friends that I want to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please complete the survey below that ask about your use of HEALTHCARE SERVICES. You can skip any questions that you do not feel comfortable answering.

Have you ever had a total joint replacement? Yes
 No

Check all total joint replacement surgeries you've had. Right Hip
 Right Knee
 Left Hip
 Left Knee
 Other

If Other, please specify. _____

Please list the date of the joint replacement/s (month and year) _____

Are you considering having joint replacement surgery at this time? Yes
 No

On a scale from 1-10, how strongly do you feel that you will need HIP surgery in the next year? 1 being not strongly and 10 being very strongly. 1 2 3 4
 5 6 7 8
 9 10

On a scale from 1-10, how strongly do you feel that you will need KNEE surgery in the next year? 1 being not strongly and 10 being very strongly. 1 2 3 4
 5 6 7 8
 9 10

Please complete the survey below that asks about PAIN, STIFFNESS, AND FUNCTION OF YOUR KNEES AND HIPS. Select one number only for each question.

The following questions concern the amount of PAIN you are currently experiencing in your hips and/or knees. For each situation, please indicate the amount of pain you recently experienced using the following scale: None, Mild, Moderate, Severe, Extreme.

QUESTION: How much PAIN do you have?

	None	Mild	Moderate	Severe	Extreme
61) Walking on a flat surface	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
62) Going up or down stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
63) At night while in bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
64) Sitting or lying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
65) Standing upright	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions concern the amount of joint STIFFNESS (not pain) you are currently experiencing in your hips and/or knees. Stiffness is a sensation of restriction or slowness in the ease with which you move your joints. Select one number only for each question.

	None	Mild	Moderate	Severe	Extreme
66) How severe is your stiffness after first waking in the morning?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
67) How severe is your stiffness after sitting, lying, or resting later in the day?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The following questions concern your PHYSICAL FUNCTION. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you are currently experiencing due to arthritis in your hips and/or knees. Select one number only for each question.

QUESTION: What degree of difficulty do you have with...

	None	Mild	Moderate	Severe	Extreme
68) Descending (walking DOWN) stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
69) Ascending (walking UP) stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
70) Rising from sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
71) Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
72) Bending to the floor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
73) Walking on a flat surface	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
74) Getting in/ out of a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
75)					

Going shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
76) Putting on socks/ stockings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
77) Rising from bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
78) Taking off socks/ stockings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
79) Lying in bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
80) Getting in/ out of the bathtub	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
81) Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
82) Getting on/ off of the toilet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
83) Heavy domestic duties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
84) Light domestic duties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>











Please complete the survey below that asks about your current LEVEL OF PHYSICAL ACTIVITY.

Rapid Assessment of Physical Activity

Physical Activities are activities where you move and increase your heart rate above its resting rate, whether you do them for pleasure, work, or transportation.

The following questions ask about the amount and intensity of physical activity you usually do. The intensity of the activity is related to the amount of energy you use to do these activities.

Examples of Activities:

<p>Light activities</p> <ul style="list-style-type: none"> • your heart beats slightly faster than normal • you can talk and sing 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Walking Leisurely</p> </div> <div style="text-align: center;">  <p>Stretching</p> </div> <div style="text-align: center;">  <p>Vacuuming or Light Yard Work</p> </div> </div>
<p>Moderate activities</p> <ul style="list-style-type: none"> • your heart beats faster than normal • you can talk but not sing 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Fast Walking</p> </div> <div style="text-align: center;">  <p>Aerobics Class</p> </div> <div style="text-align: center;">  <p>Strength Training</p> </div> <div style="text-align: center;">  <p>Swimming Gently</p> </div> </div>
<p>Vigorous activities</p> <ul style="list-style-type: none"> • your heart rate increases a lot • you can't talk or your talking is broken up by large breaths 	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;">  <p>Stair Machine</p> </div> <div style="text-align: center;">  <p>Jogging or Running</p> </div> <div style="text-align: center;">  <p>Tennis, Racquetball, Pickleball or Badminton</p> </div> </div>

89) I rarely or never do physical activity.

- Yes
 No

-
- 90) I do some LIGHT or MODERATE physical activities, but not every week. Yes
 No
-
- 91) I do some LIGHT physical activity every week. Yes
 No
-
- 92) I do MODERATE physical activity every week, but less than 30 minutes a day or 5 days a week. Yes
 No
-
- 93) I do VIGOROUS physical activity every week, but less than 20 minutes, 3 or more days per week. Yes
 No
-
- 94) I do 30 minutes or more per day of MODERATE physical activities, 5 or more days a week Yes
 No
-
- 95) I do 20 minutes of more a day of VIGOROUS physical activities, 3 or more days a week Yes
 No
-
- 96) I do activities to increase muscle STRENGTH, such as lifting weights or calisthenics, once a week or more. Yes
 No
-
- 97) I do activities to increase FLEXIBILITY, such as stretching or yoga, once a week or more. Yes
 No
-
- 98) Sometimes I feel unsteady when I am walking. Yes
 No
-
- 99) I steady myself by holding onto furniture when walking at home. Yes
 No