Illinois Pathways to Health by AgeOptions

Last Revised 8/20/23

Actice Choices Participant Pre-Survey

Participant Number or Name: _____

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

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

Program Name:

☐ Active Choices

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1. How did you hear about this class?

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

2. Did your doctor or other health care provider suggest that you attend this program?

☐ Yes ☐ No

3. How old are you today? _____ years

4. Do you live alone? ☐ Yes ☐ No

5. Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

6. 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): _____

7. What is your current gender? **Select ONE**.

- ☐ Man
- ☐ Woman
- ☐ Non-binary
- ☐ _____ (please specify)
- ☐ Prefer not to answer

8. Do you consider yourself to be transgender?

☐ Yes ☐ No ☐ Prefer not to answer

9. 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

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

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

11. Have you ever served in the military? ☐ Yes ☐ No

12. 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

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

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

14. 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			Chronic Pain		
Anxiety Disorder			Depression		
Arthritis/Rheumatic Disease			Diabetes (High Blood Sugar)		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Heart Disease		
Cancer or Cancer Survivor			High Cholesterol		

14. Continued from page 2	YES	NO		YES	NO
Hypertension (High Blood Pressure)	☐	☐	Schizophrenia or other Psychotic Disorder	☐	☐
Kidney Disease	☐	☐	Stroke	☐	☐
Malnutrition	☐	☐	Substance Use Disorder	☐	☐
Obesity	☐	☐	Urinary Incontinence	☐	☐
Osteoporosis (Low Bone Density)	☐	☐	Other Chronic Condition	☐	☐
Post-Traumatic Stress Disorder	☐	☐			

15. 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?	☐	☐

16. How often do you feel lonely?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

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

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

18. 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