

# Fit and Strong Participant Post-Survey

**Participant Number or Name:** \_\_\_\_\_

**Participant Date of Birth:** \_\_\_ / \_\_\_ / \_\_\_ (e.g., 12/01/21)

**Workshop ID:** \_\_\_ (e.g., 01, 02, 03, etc.)

**Provider Name:** \_\_\_\_\_ (e.g., XYZ Organization)

**Start date of program:** \_\_\_ / \_\_\_ / \_\_\_ (e.g., 12/01/21)

**Program Name:**

Fit and Strong!

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

Excellent     Very Good     Good     Fair     Poor

2. 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

3. How often do you feel lonely or isolated from those around you?

Always     Often     Sometimes     Rarely     Never

4. The UCLA 3-item Loneliness scale:

	Hardly ever	Some of the time	Often
a. How often do you feel that you lack companionship?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. How often do you feel left out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. How often do you feel isolated from others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. After taking this class, how well do you feel the expectations of this program were communicated?

Very well     Moderately well     Slightly well     Not well at all

6. The class helped me achieve the goals I set in my action plan(s):

Yes     No

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7. Please tell us to what extent you agree that the program has been helpful: **Check one box for each question.**

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strong Disagree
Manage a chronic condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continue to work or perform other daily activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cope with feelings such as anger, frustration, sadness, depression, or fear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manage stress and fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat healthier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increase physical activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with health professionals or a care team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Socialize more with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Since this program began, what have you done to manage your chronic condition(s) **Check all that apply.**

<input type="checkbox"/>	Talked with a friend or family member about my chronic condition(s)
<input type="checkbox"/>	Talked with a health care provider about a self-management technique I learned in this program
<input type="checkbox"/>	Made a change in my diet or eating habits
<input type="checkbox"/>	Exercised or implemented additional physical activity into my daily routine
<input type="checkbox"/>	Connected with other participants and continued to socialize with them outside of this program
<input type="checkbox"/>	Reviewed my medications and/or medication habits and made changes as necessary

9. Since this program began, I have applied the skills I learned in this program to: **Check all that apply.**

<input type="checkbox"/>	Manage emotions like stress, depression, anger, fear, or frustration
<input type="checkbox"/>	Manage pain, fatigue, or other symptoms of my chronic condition(s)
<input type="checkbox"/>	Increase my strength, flexibility, endurance, or overall physical fitness
<input type="checkbox"/>	Make a medication list that includes all current medications, dosages, and dates started
<input type="checkbox"/>	Solve a problem or issue I was experiencing in my life
<input type="checkbox"/>	Help someone else use a technique I learned in this program

10. After taking this workshop, I am feeling \_\_\_\_\_ about my health:

Much better    Better    About the same    Worse    Much worse

11. After taking this workshop, I am feeling \_\_\_\_\_ about my ability to manage my chronic condition(s):

Much better    Better    About the same    Worse    Much worse

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12. In general, I would say that my sense of well-being is:

- Excellent     Very Good     Good     Fair     Poor

13. How likely is it that you would recommend this program to a friend or family member?

Not at all likely      0   1   2   3   4   5   6   7   8   9   10      Extremely likely

14. Would you be willing to share your story to help other people gain access to these programs?

- Yes     No

15. What is most valuable to you in this program?

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16. Please provide any thoughts or feedback about the program leader(s):

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17. Please provide any other information you would like us to know:

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