

# Walk with Ease Participant Pre-Survey

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

**Workshop ID:** \_\_\_\_\_ **Site Name:** \_\_\_\_\_

**Start date of program:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (e.g., 05/01/23)

**Program Name:**

Walk with Ease

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
- I use a different term (please specify) \_\_\_\_\_
- Straight, that is, not gay or lesbian
- Don't know
- Bisexual
- Prefer not to answer
- [If respondent is AIAN:] Two-Spirit

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

<input type="checkbox"/>	Some elementary, middle, or high school	<input type="checkbox"/>	Some college or technical school
<input type="checkbox"/>	High school graduate or GED	<input type="checkbox"/>	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

19. How confident are you in managing your joint pain and stiffness?

Not at all confident    0    1    2    3    4    5    6    7    8    9    10    Very confident

20. How many days during the week do you go for a walk/s?

0     1     2     3     4     5     6     7

21. On average, how many minutes do you walk on **each** of those days? \_\_\_\_\_ minutes