



Active Choices Pre-Survey CCDPH Participant Information Form

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:

- | | | |
|---|---|---|
| <input type="checkbox"/> Take Charge of Your Health | <input type="checkbox"/> Take Charge of Your Pain | <input type="checkbox"/> wCDSMP |
| <input type="checkbox"/> Take Charge of Your Diabetes | <input type="checkbox"/> Cancer: Thriving and Surviving | <input type="checkbox"/> Active Choices |

What is your preferred language? _____

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 | |

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

- Yes No

2. From what health system do you receive your primary healthcare care services?

Advocate Aurora Health	Mercy Health Corporation
Amita Health	NorthShore University Health System
Blessing Health System	Northwestern Memorial Health Care
Carle Health	OSF Health Care
Cook County Health	Presence Health
Edward-Elmhurst Health	Rush
Hospital Sisters Health System	Sinai Chicago
Kindred Healthcare	Southern Illinois Healthcare
Loyola Medicine	Swedish American Health System
Memorial Health System	

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3. How old are you today? _____ years

4. How would you describe your gender?

Male	Trans Female/Trans Woman
Female	Not listed above Please specify: _____
Genderqueer/Gender Non-Conforming	Decline to answer
Trans Male/Trans Man	

5. What sex were you assigned at birth, such as on an original birth certificate?

Male	Intersex
Female	Decline to answer

6. Sexual orientation:

Lesbian	Straight
Gay	Something else
Bisexual	Questioning
Queer	Decline to answer

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

8. What is your race? **Check all that apply.**

American Indian or Alaska Native	Native Hawaiian or other Pacific Islander
Asian	White
Black or African American	

9. Are you deaf or do you have serious difficulty hearing? Yes No

10. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

Yes No

11. Do you live alone? Yes No

12. 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)

13. Have you ever served in the military? Yes No

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14. 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

15. In general, would you say that your health is:
 Excellent Very Good Good Fair Poor

16. Has a health care provider ever told you that you have any of the following chronic conditions?

	YES	NO		YES	NO
Anxiety Disorder			Chronic Pain		
High Cholesterol			Kidney Disease		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Obesity		
Hypertension (High Blood Pressure)			Schizophrenia or Other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Arthritis/Rheumatic Disease		
Heart Disease			Other Chronic Condition		

17. Because of a physical, mental, or emotional condition, do you:

- o Have serious difficulty concentrating, remembering, or making decisions?
 Yes No
- o Have difficulty doing errands alone such as visiting a doctor's office or shopping?
 Yes No

18. Do you have serious difficulty walking or climbing stairs? Yes No

19. Do you have difficulty dressing or bathing? Yes No

20. How often do you feel lonely or isolated from those around you?
 Always Often Sometimes Rarely Never

21. 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

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22. 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"/>

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

- Excellent
 Very Good
 Good
 Fair
 Poor

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