Take Charge 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:

☐ Take Charge of Your Health ☐ Take Charge of Your Pain ☐ wCDSMP
☐ Take Charge of Your Diabetes ☐ Cancer: Thriving and Surviving ☐ Active Choices

What is your preferred language? _____

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: _____

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1. Did your doctor of 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	☐		☐

Illinois Pathways to Health by AgeOptions

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3. How old are you today? _____ years

4. How would you describe your gender?

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

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

☐	Male
☐	Female
☐	Intersex
☐	Decline to answer

6. Sexual orientation:

☐	Lesbian
☐	Gay
☐	Bisexual
☐	Queer
☐	Straight
☐	Something else
☐	Questioning
☐	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
☐	Asian
☐	Black or African American
☐	Native Hawaiian or other Pacific Islander
☐	White

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
☐	High school graduate or GED
☐	Some college or technical school
☐	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:
    - Have serious difficulty concentrating, remembering, or making decisions?
      ☐ Yes ☐ No
    - 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

22. The UCLA 3-item Loneliness scale:

	Hardly ever	Some of the time	Often
a. How often do you feel that you lack companionship?	☐	☐	☐
b. How often do you feel left out?	☐	☐	☐
c. How often do you feel isolated from others?	☐	☐	☐

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:

_____

_____

_____