



Participant Information

Instructions: Please use a pen to answer the questions on both sides of this form. Please print clearly. Mark your choice within the box, like this:

This information is optional and will help program funders learn if this program is reaching diverse populations and helping people with chronic conditions.

I understand that filling out this form is entirely voluntary.

Please print your initials:
First Middle Last

1. What is your birth year: **OR age**
Year

2. What county do you live in? _____ (Marion, Deschutes, etc.)

3. What is your gender?

Female Male Something else/other _____

4. Are you of Hispanic, Latino, or Spanish origin?

Yes No Unknown

5. What is your race? (Mark all that apply.)

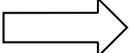
- American Indian or Alaska Native
- Asian or Asian-American
- Black or African-American
- Hawaiian Native or Other Pacific Islander
- White or Caucasian
- Something else/other: _____

6. What is the highest grade or year of school you completed? (Mark only one.)

- Some elementary, middle, or high school
- High school graduate or GED
- Some college or technical school (1 to 3 years)
- College 4 years or more (college graduate)

7. Do you now use tobacco (cigars, cigarettes, smokeless tobacco, etc.)?

Every day Some days Not at all

Please turn over 

Participant Information—continued

8. Has a health care provider ever told you that you have any of the following chronic conditions? (Mark all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Alzheimer's or related dementia | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arthritis/ rheumatic disease/
fibromyalgia | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Breathing/ lung disease (e.g.,
COPD, emphysema, bronchitis) | <input type="checkbox"/> Osteoporosis (low bone density) |
| <input type="checkbox"/> Cancer or cancer survivor | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Depression or anxiety disorder | <input type="checkbox"/> Other chronic condition:
_____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> None (no chronic conditions) |
| <input type="checkbox"/> Heart disease | |

9. 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

10. Are you limited in any way in any activities because of physical, mental, or emotional problems?

- Yes No

11. Today, how many people live in your household (including yourself)?

(Number of people)

12. How did you hear about this workshop? (Mark all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Doctor, nurse, or other health care provider's office | |
| <input type="checkbox"/> Health insurance plan | |
| <input type="checkbox"/> Community or faith-based organization/senior center | |
| <input type="checkbox"/> Work | <input type="checkbox"/> Newspaper/radio/TV |
| <input type="checkbox"/> Friend/family | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Tobacco Quit Line | <input type="checkbox"/> Other: _____ |

Thank You