

# Missouri Participant Information Survey

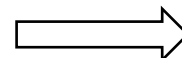
Instructions: Please use a pen to answer the questions on both sides of this form. Please print clearly. Mark your choices within the box, like this:

**Participant I.D.** (first two letters of your first name, first two letters of your last name, last two numbers of your birth year): \_\_\_\_\_

- 1) **How old are you today?** \_\_\_\_\_ years
- 2) **Are you:**  Female  Male
- 3) **Are you of Hispanic, Latino, or Spanish origin?**  Yes  No
- 4) **What is your race? (Mark all that apply)**
  - American Indian or Alaska Native
  - Asian
  - Black or African American
  - Native Hawaiian or other Pacific Islander
  - White
- 5) **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
- 6) **Which of the following best describes your health insurance status? (Please mark all that apply)**
  - Medicaid  Medicare  Uninsured
  - Insured (e.g., covered through work, bought insurance through Missouri Marketplace, bought insurance on your own, covered under a spouse's plan, etc.)
- 7) **Has a health care provider told you that you have any of the following chronic conditions? (Please mark all that apply)**

<input type="checkbox"/> Arthritis/Rheumatic Disease	<input type="checkbox"/> Hypertension (High Blood Pressure)
<input type="checkbox"/> Asthma/Emphysema/Other Chronic Breathing or Lung Problem	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Cancer or Cancer Survivor	<input type="checkbox"/> Obesity
<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Osteoporosis (Low Bone Density)
<input type="checkbox"/> Depression or Anxiety Disorders	<input type="checkbox"/> Schizophrenia or Other Psychotic Disorder
<input type="checkbox"/> Diabetes (High Blood Sugar)	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Other Chronic Condition
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> None (No Chronic Conditions)

Please turn over



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- 8) **Because of a physical, mental, or emotional condition, do you have serious difficulty walking or climbing stairs, dressing or bathing, or doing errands alone such as visiting a doctor's office or shopping?**  
 Yes  No
- 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 with glasses?**  
 Yes  No
- 11) **Did your doctor or other health care provider suggest that you take this program?**  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) **Do you live alone?**  Yes  No
- 15) **During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?**  
 Yes  No
- 16) **Has a doctor or other health professional ever suggested physical activity or exercise to help your arthritis or joint symptoms?**  
 Yes  No
- 17) **What type of physical activity or exercise did you spend the most time doing during the past month?** \_\_\_\_\_  
**Any other types?** \_\_\_\_\_
- 18) **Please think about the past 30 days, keeping in mind all of your joint pain or aching and whether or not you have taken medication. During the past 30 days, how bad was your joint pain on average?**

0 – no pain or aching; 10 pain or aching as bad as can be



Eastern RAC

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TO BE COMPLETED AT LAST PROGRAM SESSION

*Please circle the number that best matches how confident you are feeling.*

- 19) **After taking this workshop, I am more confident that I can manage my chronic condition(s).**      **1 – Not at all confident; 10 totally confident**

1	2	3	4	5	6	7	8	9	10
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