OMB Control No. 0985-0036
Exp. Date 10/31/2019

Northeast RAC

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

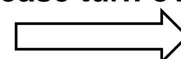
6) **Which of the following best describes your health insurance status? (Please mark all that apply)**
   - ☐ Medicaid ☐ Medicare ☐ Uninsured
   - ☐ Insured (e.g., covered through work, bought insurance through Missouri Marketplace, bought insurance on your own, covered under a spouse's plan, etc.)

7) **Has a health care provider told you that you have any of the following chronic conditions? (Please mark all that apply)**
   - ☐ Arthritis/Rheumatic Disease
   - ☐ Asthma/Emphysema/Other Chronic Breathing or Lung Problem
   - ☐ Cancer or Cancer Survivor
   - ☐ Chronic Pain
   - ☐ Depression or Anxiety Disorders
   - ☐ Diabetes (High Blood Sugar)
   - ☐ Heart Disease
   - ☐ High Cholesterol
   - ☐ Hypertension (High Blood Pressure)
   - ☐ Kidney Disease
   - ☐ Obesity
   - ☐ Osteoporosis (Low Bone Density)
   - ☐ Schizophrenia or Other Psychotic Disorder
   - ☐ Stroke
   - ☐ Other Chronic Condition
   - ☐ None (No Chronic Conditions)

ma4 Missouri Association of Area Agencies on Aging

RAC Missouri REGIONAL ARTHRITIS CENTERS

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

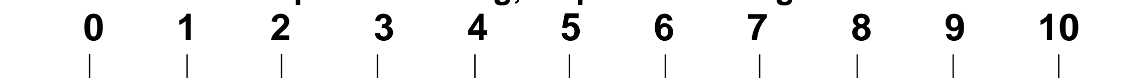
16) **Has a doctor or other health professional ever suggested physical activity or exercise to help your arthritis or joint symptoms?**
☐ Yes ☐ No

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

0 1 2 3 4 5 6 7 8 9 10



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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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