

AMOB Registration Supplement

Date: _____

INSTRUCTIONS: Fill in the answers that BEST describe you.

You may leave any question blank if you are not comfortable answering it.

1. First Name: _____	2. Last Name: _____
3. What is your address?	
_____	_____
Street Address	City
_____	_____
County	State
	Zip Code
4. What is your phone number? (____) _____-_____	
5. What is your email address? _____	
6. What is your date of birth? (MM-DD-YYYY) ____/____/_____	
7. What is your primary language?	English <input type="radio"/> Spanish <input type="radio"/> Other: _____ <input type="radio"/>
8. What is your marital status?	Married <input type="radio"/> Single <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/>
9. What is your insurance coverage?	Medicare <input type="radio"/> Medicaid <input type="radio"/> Private Insurance <input type="radio"/> Veterans Benefits <input type="radio"/> None <input type="radio"/> Other: _____ <input type="radio"/>
10. Do you have a Medicare Advantage Plan?	Yes <input type="radio"/> No <input type="radio"/>
If yes, with who? _____	<input type="radio"/>
11. How many people are in your household, including yourself? _____	
12. Please indicate your monthly income. If you are married, please indicate the income that best represents your combined monthly income. \$ _____	

13. I am a Veteran.	Yes <input type="radio"/>	No <input type="radio"/>
14. I have a family member on active military duty.	Yes <input type="radio"/>	No <input type="radio"/>
15. Would you like to be contacted about future health care education classes and event?	Yes <input type="radio"/>	No <input type="radio"/>
16. Can we contact you by text?	Yes <input type="radio"/>	No <input type="radio"/>
17. Emergency Contact Information:		
Name	Phone Number	Relationship
18. Do you have a primary care doctor or health care provider?		
	Yes <input type="radio"/>	No <input type="radio"/>
19. If yes, please provide health care provider information.		
Name	Phone Number	

I authorize the collaborators of this workshop to use this data for analysis to identify the benefits of this workshop for individuals with chronic diseases and their caregivers.

Your information will remain confidential:

(Signature)

AMOB Pre-Survey Supplement

First & Last Name: _____ Today's Date: _____

General Health

1. Thinking about your *physical health*, which includes physical illness and injury, for *how many days* during the past 30 days was your *physical health* NOT good?
 - Number of Days: _____
 - None
2. Thinking about your *mental health*, which includes stress, depression, and problems with emotions, for *how many days* during the past 30 days was your *mental health* NOT good?
 - Number of Days: _____
 - None
3. During the past 30 days, for about *how many days* did *poor physical or mental health* keep you from doing your usual activities, such as self-care, work, or recreation?
 - Number of Days: _____
 - None

Physical Activity

4. Mark only one box to tell us how much you are walking or exercising now:
 - I do not exercise or walk regularly now, and I do not intend to start
 - I do not exercise or walk regularly, but I have been thinking of starting
 - I am trying to start to exercise or walk.
 - I have exercised or walked infrequently for over a month
 - I am doing moderate exercise less than 3 times per week
 - I have been doing moderate exercise 3 or more times per week

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

Fall History		
5. In the past 3 months, how many TIMES did you go to a hospital or emergency department due to a fall or fall-related injury?	_____	Times
6. In the past 3 months, how many TIMES were you hospitalized for one night or longer due to a fall or fall-related injury?	_____	Times
7. In the past 3 months, how many NIGHTS did you spend in the hospital due to a fall or fall-related injury?	_____	Nights
8. During the last 30 days, were you hospitalized overnight due to a fall?	Yes <input type="radio"/>	No <input type="radio"/>
9. How many different times did you stay in any hospital overnight or longer during the past 30 days due to a fall?	_____	Times
10. How many nights were you in the hospital during the past 30 days due to a fall?	_____	Nights
11. During the past 30 days, did you see a doctor or other healthcare professional at an emergency room due to a fall? (Do not include times you stayed in hospital overnight)	Yes <input type="radio"/>	No <input type="radio"/>

I authorize the collaborators of this workshop to use this data for analysis to identify the benefits of this workshop for individuals with chronic diseases and their caregivers.

Your information will remain confidential:

(Signature)

A Matter of Balance Participant Information Form

OMB Control No. 0985-0039
Exp. Date 03/31/2021

Today's date: / /
 M M D D Y Y Y Y

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. Did your doctor, nurse, physical therapist or other health care provider suggest that you take this program?

Yes No

2. How old are you today? _____ years

3. Do you live alone? Yes No

4. Are you: Male or Female?

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

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

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

7. What is the highest grade or level of school that you have completed?

- Less than high school
- High school graduate or GED
- Some high school
- Some college or vocational school
- College graduate or higher

8. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)? **Check Yes or No.**

Arthritis or other bone/joint disease	<input type="radio"/> Yes <input type="radio"/> No	High blood pressure/hypertension	<input type="radio"/> Yes <input type="radio"/> No
Breathing/lung disease	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma/other chronic eye problem	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Depression	<input type="radio"/> Yes <input type="radio"/> No	Parkinson's Disease	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Other Chronic Condition(s) (specify):	_____
Heart disease or blood circulation problem	<input type="radio"/> Yes <input type="radio"/> No		_____

9. Are you limited in any way in any activities because of physical, mental, or emotional problems? Yes No

Please turn this paper over and fill out the other side.

10. In general, would you say that your health is:

- Excellent Very good Good Fair Poor

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

11. In the past 3 months, how many times have you fallen? none _____times

If you fell in the past 3 months:

a. how many of these falls caused an injury? (By an injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor.)

_____number of falls causing an injury

b. where did the fall(s) occur (Please check all that apply)?

- Indoors Outdoors Both indoors and outdoors

c. what happened after you fell and had an injury? (Please check all that apply)

- Went to the Emergency Room Was admitted to the hospital

- Visited my Primary Care Physician Did not seek medical care _____

12. How fearful are you of falling?

- Not at all A little Somewhat A lot

13. Please mark the circle that tells us how sure you are that you can do the following activities.

How sure are you that:

	Very Sure	Sure	Somewhat sure	Not at all sure
a. I can find a way to get up if I fall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I can find a way to reduce falls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I can protect myself if I fall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I can increase my physical strength	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I can become more steady on my feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

14. During the last 4 weeks, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups?

- Extremely Quite a bit Moderately Slightly Not at all

15. I have made safety modifications in my home, such as installing grab bars or securing loose rugs, to reduce my risk of falling ___ True ___ False

16. What best describes your activity level?

- Vigorously active for at least 30 min, 3 times per week
 Moderately active at least 3 times per week
 Seldom active, preferring sedentary activities

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0985-0039. The time required to complete this information collection is estimated to average 6 minutes per response. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Administration for Community Living, 330 C St SW, Washington, DC 20201, Attention: PRA Reports Clearance Officer.

A Matter of Balance-Participant Post Program Survey

Today's date: / /
M M D D Y Y Y Y

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. In general, would you say that your health is:

- Excellent Very good Good Fair Poor

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

2. Since this program began, how many times have you fallen? none _____ times

If you fell since the program began:

a. how many of these falls caused an injury? *(By an injury we mean the fall caused you to limit your regular activities for at least a day or to go see a doctor.)*

_____ number of falls causing an injury

b. where did the fall(s) occur *(Please check all that apply)?*

- Indoors Outdoors Both indoors and outdoors

c. what happened after you fell and had an injury? *(Please check all that apply)*

- Went to the Emergency Room Was admitted to the hospital
 Visited my Primary Care Physician Did not seek medical care

3. How fearful are you of falling?

- Not at all A little Somewhat A lot

4. Please mark the circle that tells us how sure you are that you can do the following activities.

How sure are you that:

	Very Sure	Sure	Somewhat	Not at all sure
a. I can find a way to get up if I fall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I can find a way to reduce falls	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I can protect myself if I fall	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I can increase my physical strength	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I can become more steady on my feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please turn this paper over and fill out the other side.

Participant Post Program Survey (continued)

5. During the last 4 weeks, to what extent has your concern about falling interfered with your normal social activities with family, friends, neighbors or groups?

- Extremely
 Quite a bit
 Moderately
 Slightly
 Not at all

6. Please tell us your thoughts about this program. **Check one circle for each question.**

As a result of this program:	Strongly Agree	Agree	Disagree	Strongly Disagree
a. I feel more comfortable talking to my health care provider about my medications and other possible risks for falling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I feel more comfortable talking to my family and friends about falling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I feel more comfortable increasing my activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I feel more satisfied with my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I would recommend this program to a friend or relative	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Since this program began, what have you done to reduce your chance of a fall?
Check all that apply.

- Talked to a family member or friend about how I can reduce my risk of falling
 Talked to a health care provider about how I can reduce my risk of falling
 Had my vision checked
 Had my medications reviewed by a health care provider or pharmacist
 Participated in another fall prevention program in my community

8. I have made safety modifications in my home, such as installing grab bars or securing loose rugs, to reduce my risk of falling. ___ True ___ False

9. What best describes your activity level?

- Vigorously active for at least 30 min, 3 times per week
 Moderately active at least 3 times per week
 Seldom active, preferring sedentary activities

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0985-0039. The time required to complete this information collection is estimated to average 6 minutes per response. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Administration for Community Living, 330 C St SW, Washington, DC 20201, Attention: PRA Reports Clearance Officer.

AMOB Post-Survey Supplement

First & Last Name: _____ Today's Date: _____

General Health

1. Thinking about your *physical health*, which includes physical illness and injury, for *how many days* during the past 30 days was your *physical health* NOT good?
 - Number of Days: _____
 - None
2. Thinking about your *mental health*, which includes stress, depression, and problems with emotions, for *how many days* during the past 30 days was your *mental health* NOT good?
 - Number of Days: _____
 - None
3. During the past 30 days, for about *how many days* did *poor physical or mental health* keep you from doing your usual activities, such as self-care, work, or recreation?
 - Number of Days: _____
 - None

Physical Activity

4. Mark only one box to tell us how much you are walking or exercising now:
 - I do not exercise or walk regularly now, and I do not intend to start
 - I do not exercise or walk regularly, but I have been thinking of starting
 - I am trying to start to exercise or walk.
 - I have exercised or walked infrequently for over a month
 - I am doing moderate exercise less than 3 times per week
 - I have been doing moderate exercise 3 or more times per week

The next few questions ask about falls. By a fall, we mean when a person unintentionally comes to rest on the ground or another lower level.

Fall History		
5. During the last 30 days, were you hospitalized overnight due to a fall?	Yes ○	No ○
6. How many different times did you stay in any hospital overnight or longer during the past 30 days due to a fall?	_____ Times	
7. How many nights were you in the hospital during the past 30 days due to a fall?	_____ Nights	
8. During the past 30 days, did you see a doctor or other healthcare professional at an emergency room due to a fall? (Do not include times you stayed in hospital overnight)	Yes ○	No ○

I authorize the collaborators of this workshop to use this data for analysis to identify the benefits of this workshop for individuals with chronic diseases and their caregivers.

Your information will remain confidential:

(Signature)



A MATTER OF
BALANCE

MANAGING CONCERNS ABOUT FALLS

30 Day Follow Up Survey

Please answer the following questions, all responses will be kept private.

Name: Date:

1. During the last **30 days**, were you hospitalized **overnight**?
 Yes
 No

2. How many different **times** did you stay at any hospital **overnight or longer** during the past **30 days**?
 Number of **Times**: _____
 None

3. Altogether, how many **nights** were you in the hospital during the **past 30 days**?
 Number of **Nights**: _____
 None

4. During the last **30 days**, did you see a doctor or other healthcare professional at an **emergency room**? (Do not include times you stayed in the hospital overnight)
 Yes
 No

5. Would you say your health in general is?

- Excellent
- Very good
- Good
- Fair
- Poor

6. Now thinking about your **physical health**, which includes physical illness and injury, for how many days during the **past 30 days** was your physical health **not good**?

- Number of **Days**: _____
- None

7. Now thinking about your **mental health**, which includes stress, depression, and problems with emotions, for how many days during the **past 30 days** was your mental health **not good**?

- Number of **Days**: _____
- None

If you answered "None" for questions 6 & 7, please do not answer question 8

8. During the **past 30 days**, for about how many days did poor **physical or mental health** keep you from doing your usual activities, such as work or daily tasks?

- Number of **Days**: _____
- None

Thank you so much for completing our 30 Day Follow Up Survey!

For Office Use Only!	
ID:	
Workshop:	

13. Do you have a Medicare Advantage Plan? If yes, with who? _____	Yes <input type="radio"/>	No <input type="radio"/>		
14. How many people are in your household, including yourself? _____				
15. Please indicate your monthly income. If you are married, please indicate the income that best represents your combined monthly income. \$ _____				
16. Please select your highest level of education.				
Less than high school <input type="radio"/>	Some high school <input type="radio"/>	High school graduate or GED <input type="radio"/>	Some college or vocational school <input type="radio"/>	College graduate or higher <input type="radio"/>
Health Information				
17. Has a healthcare provider ever told you that you have any of the following chronic conditions? (Select all that apply)				
<input type="radio"/> Arthritis or other bone/joint problem	<input type="radio"/> High blood pressure (hypertension)			
<input type="radio"/> Breathing/lung disease (asthma, emphysema, bronchitis)	<input type="radio"/> Kidney disease			
<input type="radio"/> Cancer or cancer survivor	<input type="radio"/> Low bone density (osteoporosis)			
<input type="radio"/> Chronic pain	<input type="radio"/> Obesity			
<input type="radio"/> Depression or anxiety disorder	<input type="radio"/> Schizophrenia or other psychotic disorder			
<input type="radio"/> Prediabetes	<input type="radio"/> Stroke			
<input type="radio"/> Type I diabetes	<input type="radio"/> Other chronic conditions (specify): _____ _____ _____			
<input type="radio"/> Type II diabetes				
<input type="radio"/> Heart disease				
<input type="radio"/> High cholesterol	<input type="radio"/> None (no chronic conditions)			
Other Information				
18. I am a Veteran.				
	Yes <input type="radio"/>	No <input type="radio"/>		
19. I have a family member on active military duty.				
	Yes <input type="radio"/>	No <input type="radio"/>		
20. Would you like to be contacted about future health care education classes or events?				
	Yes <input type="radio"/>	No <input type="radio"/>		

Please fill in marks like this: ●

Form A

21. Can we contact you by text?

Yes

No

22. Emergency Contact Information:

Name

Phone Number

Relationship

23. Do you have a primary care doctor or health care provider?

Yes

No

24. If yes, please list health care provider information.

Name

Phone Number

25. Who suggested you take this program?

(Circle all that apply)

- Doctor, Nurse, or other Healthcare Provider
- The Area Agency on Aging (AAA)
- Another health education class/workshop
- Friend or Family Member
- United Way Referral System
- Senior Center or Community Center
- Faith-Based Organization
- Work
- Newspaper, Radio, or TV
- Other: _____

I authorize the collaborators of this workshop to use this data for analysis to identify the benefits of this workshop for individuals with chronic diseases and their caregivers.

Your information will remain confidential:

(Signature)

CDSMP/DSMP Registration Supplemental

Date: _____

INSTRUCTIONS: Fill in the answers that BEST describe you.

You may leave any question blank if you are not comfortable answering it.

<p>1. 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?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>2. Are you deaf or do you have serious difficulty hearing?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>3. Are you blind or do you have serious difficulty seeing even with glasses?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>
<p>4. 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 the doctor's office or shopping?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p>

I authorize the collaborators of this workshop to use this data for analysis to identify the benefits of this workshop for individuals with chronic diseases and their caregivers.

Your information will remain confidential:

(Signature)

CDSMP/DSMP Participant Pre-Survey

First & Last Name: _____ Today's Date: _____

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Thinking about your *physical health*, which includes physical illness and injury, for *how many days* during the past 30 days was your *physical health* NOT good?

- Number of Days: _____
- None

3. Thinking about your *mental health*, which includes stress, depression, and problems with emotions, for *how many days* during the past 30 days was your *mental health* NOT good?

- Number of Days: _____
- None

4. During the past 30 days, for about *how many days* did *poor physical or mental health* keep you from doing your usual activities, such as self-care, work, or recreation?

- Number of Days: _____
- None

5. If you have diabetes, do you know your A1C level?

Yes	No	I do not have diabetes
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. If you know your A1C, what is it? _____

Symptoms

7. How many times during the *past 2 weeks*...

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
a) Were you discouraged by your health problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Were you fearful about your future health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Was your health a worry in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) Were you frustrated by your health problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. When you are feeling down in the dumps, feeling pain, or having other unpleasant symptoms, how often do you do the following?						
	Never	Almost Never	Sometimes	Fairly Often	Very Often	Always
a) Try to feel distant from the discomfort and pretend that it is not part of your body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Don't think of it as discomfort but as some other sensation like a warm, numb feeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Play mental games or sing songs to keep your mind off of the discomfort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) Practice progressive muscle relaxation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e) Practice visualization or guided imagery such as picturing yourself somewhere else	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f) Talk to yourself in a positive way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Activity						
9. How many days in the last week did you exercise for at least 30 minutes? _____						
10. During the <i>past 2 weeks</i> , how much has your health interfered with your normal social activities, hobbies, chores, or errands?						
Not at all	Slightly	Moderately	Quite a bit	Almost totally		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Medication Management						
11. During the <i>past 2 weeks</i> , have you taken your medications exactly as prescribed your healthcare practitioner?						
Never	Almost Never	Sometimes	Fairly Often	Very Often	Always	NA
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Do you currently have an up-to-date record of your medication list?						
Yes	No	I do not take medication				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

For each of the following questions, please *bubble* the number that corresponds with your confidence that you can do the tasks regularly at the present time.

Confidence About Doing Things										
13. How confident are you that you can keep the fatigue caused by your disease from interfering with the things you want to do?										
Not at all Confident									Totally Confident	
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How confident are you that you can keep the physical discomfort or pain caused by your disease from interfering with the things you want to do?										
Not at all Confident									Totally Confident	
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How confident are you that you can keep the emotional distress caused by your disease from interfering with the things you want to do?										
Not at all Confident									Totally Confident	
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?										
Not at all Confident									Totally Confident	
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?										
Not at all Confident									Totally Confident	
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?										
Not at all Confident									Totally Confident	
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. How confident are you that you can manage your long term health conditions?										
Not at all Confident									Totally Confident	
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Do you feel you can ask your doctor questions about your healthcare or treatment plan?										
Yes, I Can			Maybe I Can		I Don't Think I Can			No, I Can't		I Don't Know If I Can
<input type="radio"/>			<input type="radio"/>		<input type="radio"/>			<input type="radio"/>		<input type="radio"/>
Medical History										
21. In the past 3 months, how many TIMES did you visit a physician?									_____ Times	
(Do not include visits while in hospital or emergency department)										
22. In the past 3 months, how many TIMES did you go to a hospital or emergency department?									_____ Times	
23. In the past 3 months, how many TIMES were you hospitalized for one night or longer?									_____ Times	
24. In the past 3 months, how many NIGHTS did you spend in the hospital?									_____ Nights	
25. During the last 30 days, were you hospitalized overnight?									Yes	No
									<input type="radio"/>	<input type="radio"/>
26. How many different times did you stay in any hospital overnight or longer during the past 30 days?									_____ Times	
27. How many nights were you in the hospital during the past 30 days?									_____ Nights	
28. During the past 30 days, did you see a doctor or other healthcare professional at an emergency room?									Yes	No
(Do not include times you stayed in hospital overnight)									<input type="radio"/>	<input type="radio"/>

I authorize the collaborators of this workshop to use this data for analysis to identify the benefits of this workshop for individuals with chronic diseases and their caregivers.

Your information will remain confidential:

(Signature)

CDSMP/DSMP Participant Post-Survey

First & Last Name: _____ Today's Date: _____

1. In general, would you say your health is:

Excellent	Very Good	Good	Fair	Poor
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. Thinking about your *physical health*, which includes physical illness and injury, for *how many days* during the past 30 days was your *physical health* NOT good?

Number of Days: _____
 None

3. Thinking about your *mental health*, which includes stress, depression, and problems with emotions, for *how many days* during the past 30 days was your *mental health* NOT good?

Number of Days: _____
 None

4. During the past 30 days, for about *how many days* did *poor physical or mental health* keep you from doing your usual activities, such as self-care, work, or recreation?

Number of Days: _____
 None

5. If you have diabetes, do you know your A1C level?

Yes	No	I do not have diabetes
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. If you know your A1C, what is it? _____

Symptoms

7. How many times during the *past 2 weeks*...

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
a) Were you discouraged by your health problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Were you fearful about your future health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Was your health a worry in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) Were you frustrated by your health problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. When you are feeling down in the dumps, feeling pain, or having other unpleasant symptoms, how often do you do the following?						
	Never	Almost Never	Sometimes	Fairly Often	Very Often	Always
a) Try to feel distant from the discomfort and pretend that it is not part of your body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Don't think of it as discomfort but as some other sensation like a warm, numb feeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Play mental games or sing songs to keep your mind off of the discomfort	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) Practice progressive muscle relaxation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e) Practice visualization or guided imagery such as picturing yourself somewhere else	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f) Talk to yourself in a positive way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Activity						
9. How many days in the last week did you exercise for at least 30 minutes? _____						
10. During the <i>past 2 weeks</i> , how much has your health interfered with your normal social activities, hobbies, chores, or errands?						
Not at all	Slightly	Moderately	Quite a bit	Almost totally		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Medication Management						
11. During the <i>past 2 weeks</i> , have you taken your medications exactly as prescribed your healthcare practitioner?						
Never	Almost Never	Sometimes	Fairly Often	Very Often	Always	NA
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Do you currently have an up-to-date record of your medication list?						
Yes	No	I do not take medication				
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				

Please fill in marks like this: ●

For each of the following questions, please *bubble* the number that corresponds with your confidence that you can do the tasks regularly at the present time.

Confidence About Doing Things										
13. How confident are you that you can keep the fatigue caused by your disease from interfering with the things you want to do?										
Not at all Confident										Totally Confident
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. How confident are you that you can keep the physical discomfort or pain caused by your disease from interfering with the things you want to do?										
Not at all Confident										Totally Confident
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. How confident are you that you can keep the emotional distress caused by your disease from interfering with the things you want to do?										
Not at all Confident										Totally Confident
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?										
Not at all Confident										Totally Confident
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?										
Not at all Confident										Totally Confident
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?										
Not at all Confident										Totally Confident
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. How confident are you that you can manage your long-term health conditions?										
Not at all Confident									Totally Confident	
0	1	2	3	4	5	6	7	8	9	10
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Do you feel you can ask your doctor questions about your healthcare or treatment plan?										
Yes, I Can		Maybe I Can		I Don't Think I Can			No, I Can't		I Don't Know If I Can	
<input type="radio"/>		<input type="radio"/>		<input type="radio"/>			<input type="radio"/>		<input type="radio"/>	
Medical History										
21. During the last 30 days, were you hospitalized overnight?									Yes	No
									<input type="radio"/>	<input type="radio"/>
22. How many different times did you stay in any hospital overnight or longer during the past 30 days?									_____ Times	
23. How many nights were you in the hospital during the past 30 days?									_____ Nights	
24. During the past 30 days, did you see a doctor or other healthcare professional at an emergency room? (Do not include times you stayed in hospital overnight)									Yes	No
									<input type="radio"/>	<input type="radio"/>

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(Signature)

Participant Satisfaction Survey

We ask you to share your responses to this workshop with us; we want to learn if we can make it even better!

Workshop Title: Chronic Disease Self-Management Program

Site: _____ Date: _____

Leaders: _____

Thank you for taking this class. Please check the answers that best reflect your opinion.

	Agree	Neutral	Disagree
1. The information provided in the workshop is practical and useful for daily living.			
2. The Leaders made the content of the workshop easy to understand.			
3. I am motivated to make lifestyle changes as a result of the workshop.			
4. The time and location of the workshop was convenient.			
5. I would recommend this workshop to others.			

