Oregon Living Well Program

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: [X]

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: ☐☐☐☐ Year **OR age** ☐☐

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.)

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

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.)

- ☐ Doctor, nurse, or other health care provider's office
- ☐ Health insurance plan
- ☐ Community or faith-based organization/senior center
- ☐ Work
- ☐ Friend/family
- ☐ Tobacco Quit Line
- ☐ Newspaper/radio/TV
- ☐ Internet
- ☐ Other: _____

Thank You