Participant Name: ___________________________  Doctors Name: ___________________________

Living Well with Chronic Conditions classes held in: ______________________________________

Class Dates: _____________________________  Completed 6-week series:  ☐ Yes  ☐ No

☐ Participant was contacted after referral, but did not attend. (See comments below.)

Chronic conditions I live with: _______________________________________________________

___________________________________________________________________________________

I completed workshops in the following areas:

☐ Differences between acute and chronic conditions  ☐ Endurance activities

☐ Using the mind to control symptoms  ☐ My healthcare future

☐ How to make an action plan  ☐ Healthy eating

☐ Problem solving skills  ☐ Communication skills

☐ Dealing with difficult emotions  ☐ Medication usage

☐ Physical activity and exercise  ☐ Depression management

☐ Better breathing  ☐ Positive thinking

☐ Muscle relaxation  ☐ Guided imagery

☐ Pain and fatigue management  ☐ Working with my healthcare professional

My current goals:

___________________________________________________________________________________

___________________________________________________________________________________

Concerns/Additional comments: _______________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Thank you,

_________________________  _____________________
Signature of participant Date

_________________________  _____________________
Leader Signature Date