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

Paths to Health NM: *Tools for Healthier Living*

Chronic Disease Self-Management Education Programs

Participant Information

Participant ID ☐☐☐☐☐☐

(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** ❍ Male **or** ❍ Female **?**
3	**Are you of Hispanic, Latino or Spanish origin?** ❍ Yes ❍ No
4	**What is your race?** *(Mark all that apply)* ❍ American Indian or Alaskan Native ❍ Asian ❍ Black or African-American ❍ Native Hawaiian or other Pacific Islander ❍ White
5	**Has a healthcare provider ever told you that you have any of the following chronic conditions?** *(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 ❍ Osteoporosis (Low Bone Density) ❍ Obesity ❍ Schizophrenia or Other Psychotic Disorder ❍ Stroke ❍ Other Chronic Condition ______________________ ❍ None (No Chronic Conditions)
6	**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
7	**Are you deaf or do you have serious difficulty hearing?** ❍ Yes ❍ No
8	**Are you blind or do you have serious difficulty seeing even with glasses?** ❍ Yes ❍ No
9	**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
10	**Do you live alone?** ❍ Yes ❍ No

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11	**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, four years or more
12	**In general, would you say that your health is:** ❍ Excellent ❍ Very good ❍ Good ❍ Fair ❍ Poor
13	**Did your doctor or other healthcare provider suggest that you take this program?** ❍ Yes ❍ No

To be completed at *last* program session

14	**After taking this workshop, I am more confident that I can manage my chronic condition(s).** *Please circle the number that best matches how confident you are feeling.* *(Not at all confident)* **1 2 3 4 5 6 7 8 9 10** *(Totally confident)*

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