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

Paths to Health NM: *Tools for Healthier Living*

Stanford Self-Management 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

Participant Information

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)*

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 0985-0036. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. 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 Street SW, Washington, D.C. 20201, Attention: PRA Reports Clearance Officer.**