Revised November 2013

Healthier Living Workshop Questionnaire – Session 1

Your Initials: _______ _______ _______
First *Middle* *Last*

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___
Month *Day* *Year*

Sex: ☐ Male ☐ Female

Your ZIP CODE: ____ ____ ____ ____ ____

1. **Has a doctor, nurse, or other health professional ever told you that you have a chronic health condition? (Check all that apply.)**

☐ Alzheimer's or Related Dementia
☐ Anxiety disorders
☐ Arthritis
☐ Asthma/COPD/Emphysema/Bronchitis
☐ Cancer or Cancer Survivor
☐ Chronic Pain
☐ Depression
☐ Diabetes
☐ Pre-diabetes
☐ Heart disease
☐ High blood pressure
☐ High cholesterol
☐ Osteoporosis (Low Bone Density)
☐ Multiple Sclerosis
☐ Stroke
☐ Other:__________________
☐ No chronic health condition
☐ Don't know / Not sure

2. **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

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

4. **Today, how many people live in your household (including yourself)?** _______ ***(number of people)***

5. **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 4 years or more

6. **Are you of Hispanic, Latino, or Spanish origin?** ☐ Yes ☐ No ☐ Unknown

7. **What is your race? (Mark all that apply)**

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unknown / Declined

8. **Are you a Veteran of any military service?**
☐ Yes ☐ No

9. **Who is your insurance provider? (Optional)**
☐ Anthem Blue Cross
☐ Blue Shield
☐ Health Net
☐ Kaiser
☐ UnitedHealthCare
☐ Other

THANK YOU!
Please return this questionnaire to your Workshop Leaders.