

Section 1: Demographic Information

Code book

1. What is your age? _____ year-old

2. What is your gender? Male Female Other

3. What is your ethnic origin? (Check all that apply)

Chinese Asian Indian Korean Vietnamese Filipino Other: _____
 1 2 3 4 5 6

4. What is your current relationship status?

Married Living with a partner Single Other: _____
 1 2 3 4

5. Please circle the highest year of school completed.

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17+
																	(graduate school)

(primary) (middle/high school) (college/university)

6. Including yourself, how many people live in your household?

7. Who lives with you? (Check all that apply)

No one Spouse Children Grandchildren /
 Parents Grandparents Brothers/sisters /
 Other relatives Friends/roommates Other:

8. What is your religious affiliation?

None Protestant Catholic Hindu
 Muslim Buddhist Other:

9. What is your current employment status? (Check all that apply)

Employed full time Employed part time Self-employed full time /
 Self-employed part time Student Full time homemaker /
 Disabled/unable to work Unemployed Retired Other:

10. IF YOU ARE EMPLOYED, what kind of work do you do?

- Professional: lawyer, doctor, nurse, teacher, accountant, etc.
 Manager, executive, or official: store manager, business executive, etc.
 Business owner
 Clerical/office/Sales: secretary, receptionist, sales clerk, etc.
 Service work: waiter/waitress, hairstylist, police or fireman, janitor, nurses' aide, etc.
 Skilled trades: electrician, plumber, carpenter, etc.
 Semi-skilled: assembly line worker, truck driver, bus driver, etc.
 Other: _____

11. How much was your household income (before tax) for the past year?

\$0-\$9,999 \$10,000-\$19,999 \$20,000-\$29,999 \$30,000-\$39,999
 \$40,000-\$49,999 \$50,000-\$59,999 \$60,000-\$69,999 \$70,000 and over

12. Thinking of your household's total monthly income, would you say that your household is able to make ends meet?
 Yes No

Section 2: Immigration and Acculturation

1. Were you born in the United States? Yes No
2. How long have you lived in the United States? 2 years
3. Is English your primary language? Yes No
4. How well do you speak English?
 Not at all Not well Well Very well
5. How much does your English speaking ability interfere with daily life?
 Not at all Not much Much Very much
6. How would you rate your level of familiarity with the culture and custom of mainstream America?
 Very low Low High Very high
7. How would you rate your level of familiarity with the culture and custom of your ethnic origin?
 Very low Low High Very high
8. How closely do you identify with people of your ethnic origin?
 Not at all Not very close Somewhat close Very close
9. How much do you feel that you belong to the community of your ethnic origin?
 Not at all Not very much Somewhat Very much
10. Have you ever been treated unfairly because of your race or ethnic origin? Yes No

Section 3: Health

1. How would you rate your overall health at the present time?
 Excellent Very good Good Fair Poor
2. How would you rate your mental/emotional health at the present time?
 Excellent Very good Good Fair Poor
3. How would you rate your dental/oral health at the present time?
 Excellent Very good Good Fair Poor
4. Do you need help with daily activities like bathing, dressing, eating, or using the toilet? Yes No
5. Are you currently using tobacco products? Yes No
6. Has anyone ever told you that you have a drinking problem? Yes No
7. Do you exercise regularly? Yes No
8. Do you maintain a healthy diet? Yes No

9. Has a doctor ever told you that you had any of the following conditions?

Hypertension	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Arthritis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hepatitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Kidney problem	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

10. Please indicate if you have used each of the following services during the past 12 months.

A doctor, hospital or clinic for a routine physical check-up	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
A dentist for a routine check-up	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
A doctor, emergency room, or clinic for urgent care treatment (because of new symptoms, an accident, or something else unexpected)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
A folk medicine provider (e.g., herbalist, acupuncturist, etc.) for health concerns	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

11. Is there a place that you usually go to when you get sick? Yes No

12. Are you currently covered by any healthcare insurance? Yes No

13. Do you have dental insurance? Yes No

14. Was there a time in the past 12 months when you needed medical care but couldn't get it? Yes No

15. Was there a time in the past 12 months when you needed dental care but couldn't get it? Yes No

16. For your medical visit, do you need someone who can provide a ride for you? Yes No

17. For your medical visit, do you need someone who can do interpretation for you? Yes No

18. Have you had an experience that you could not understand what the doctor/nurse said? Yes No

19. If you could choose, would you prefer to be treated by a doctor of your own ethnic group? Yes No

20. How satisfied are you with the healthcare services you received in the past 12 months?

Not at all

Not very much

Pretty much

Very much

Never used

21. Where do you get health-related information? (Check all that apply)

Family member or relatives (0/1)

Email listservs (0/1)

Close friends (0/1)

Social networking sites (e.g., Facebook, Twitter) (0/1)

Acquaintances (0/1)

Online communities or groups (0/1)

Health professionals (e.g., doctors, nurses) (0/1)

Health websites (0/1)

Mobile apps (0/1)

Other: (0/1)

Section 4: Emotional Well-being

1. How would you rate your overall quality of life? Please circle the number below that describes your quality of life in general?

0	1	2	3	4	5	6	7	8	9	10
Very poor quality										Excellent quality

2. Please indicate how much you agree with each statement.

	Strongly disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly agree
In most ways my life is close to my ideal.	□	□	□	□	□	□	□
I am satisfied with my life.	□	□	□	□	□	□	□

3. The next questions are about how you have been feeling during the past 30 days.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
How often did you feel nervous?	□	□	□	□	□
How often did you feel hopeless?	□	□	□	□	□
How often did you feel restless or fidgety?	□	□	□	□	□
How often did you feel so depressed that nothing could cheer you up?	□	□	□	□	□
How often did you feel that everything was an effort?	□	□	□	□	□
How often did you feel worthless?	□	□	□	□	□

4. The next questions are about how you have been feeling during the past 7 days.

♦ How many of the past seven days did you worry a lot about little things?

<input type="checkbox"/> 0 day	<input type="checkbox"/> 1 day	<input type="checkbox"/> 2 days	<input type="checkbox"/> 3 days	<input type="checkbox"/> 4 days	<input type="checkbox"/> 5 days	<input type="checkbox"/> 6 days	<input type="checkbox"/> 7 days
0	1	2	3	4	5	6	7

♦ How many of the past seven days did you feel tense or anxious?

<input type="checkbox"/> 0 day	<input type="checkbox"/> 1 day	<input type="checkbox"/> 2 days	<input type="checkbox"/> 3 days	<input type="checkbox"/> 4 days	<input type="checkbox"/> 5 days	<input type="checkbox"/> 6 days	<input type="checkbox"/> 7 days
0	1	2	3	4	5	6	7

♦ How many of the past seven days did you feel restless?

<input type="checkbox"/> 0 day	<input type="checkbox"/> 1 day	<input type="checkbox"/> 2 days	<input type="checkbox"/> 3 days	<input type="checkbox"/> 4 days	<input type="checkbox"/> 5 days	<input type="checkbox"/> 6 days	<input type="checkbox"/> 7 days
0	1	2	3	4	5	6	7

5. During the past 12 months, have you ever felt that you might need to see a professional because of a problem with your emotional or mental health? Yes No

6. Was there a time in the past 12 months when you needed emotional or mental care but couldn't get it?

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
---	-----------------------------

7. Please indicate if you have used each of the following professionals during the past 12 months about a problem with your emotional or mental health.

A psychiatrist	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A general practitioner or other medical doctor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A psychologist, professional counselor, marriage therapist, or social worker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A minister, priest, rabbi, or other spiritual advisor	<input type="checkbox"/> Yes	<input type="checkbox"/> No

8. Please indicate your experience or opinion for the questions below.

◆ Do you think depression is a sign of personal weakness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ Do you think having a depressed family member brings a shame to the whole family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ Do you think if you have depression, your family would be disappointed with you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ Do you think keeping emotional troubles to oneself is a virtue?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ Do you think antidepressant medicines are addictive?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ Do you think people with mental problems are dangerous to others?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ Do you think people with mental problems will never recover?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ Have you ever received psychological counseling or treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ If you have depression, would you be willing to use counseling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
◆ If you use counseling, would you prefer a counselor of your own ethnic group?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section 5: Special Interest

1. How much do you know about Alzheimer's disease?

Nothing at all Not very much Somewhat Very much

2. Do any of your family members or friends have Alzheimer's disease?

Yes No

3. Please indicate your response to the following questions.

	Not at all	Not very much	Pretty much	Very much
◆ How concerned are you that YOU may have Alzheimer's disease someday?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ How concerned are you that you may someday have to provide care for someone with Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
◆ How important do you think it is to plan for the possibility of getting Alzheimer's disease in the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you made plans for the possibility of you or your family getting Alzheimer's disease?

Yes No

5. Do you know any educational programs on Alzheimer's disease?

Yes No

6. Do you know any local services and programs for Alzheimer's disease patients and family? Yes No 1 2

7. Do you think your language and/or culture would interfere with your participation in such programs? Yes No

8. Please indicate whether you agree with each of the following statements. 1 2

◆ Alzheimer's disease is a cause of fate.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
◆ Alzheimer's disease is a normal process of aging.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
◆ It is embarrassing to have a family member with Alzheimer's disease.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
◆ Social interactions with an Alzheimer's disease patient should be avoided.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
◆ Scientists will find cure for Alzheimer's disease soon.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
◆ It is not right to place a family member with Alzheimer's disease in a nursing home.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

9. Have you heard about advance directives? 1 2 Yes No

10. An advance directive is a type of legal document that designates someone who can make medical decisions in the event that you are unable to do so. Do you have such a document? 1 Yes 2 No

11. How much do you agree with the following statement?: "One should avoid speaking about bad things (e.g., disease and death) because it might cause them to happen."

Strongly disagree Somewhat disagree Somewhat agree Strongly agree

Section 6: Social and Community Resources

1. Thinking about your **FAMILY/RELATIVES**.....

◆ How many family/relatives do you see or hear from at least once a month?

0 1 2 3-4 5-8 9 or more

0 1 2 3 4 5

◆ How many family/relatives do you feel at ease with that you can talk about private matters?

0 1 2 3-4 5-8 9 or more

0 1 2 3 4 5

◆ How many family/relatives do you feel close to such that you could call on them for help?

0 1 2 3-4 5-8 9 or more

0 1 2 3 4 5

2. Thinking about your **FRIENDS**.....

◆ How many of your friends do you see or hear from at least once a month?

0 1 2 3-4 5-8 9 or more

0 1 2 3 4 5

◆ How many friends do you feel at ease with that you can talk about private matters?

0 1 2 3-4 5-8 9 or more

0 1 2 3 4 5

◆ How many friends do you feel close to such that you could call on them for help?

0 1 2 3-4 5-8 9 or more

0 1 2 3 4 5

3. For the set of questions below, please indicate how you feel about your family.

	Strongly disagree	Somewhat disagree	Somewhat agree	Strongly agree
My family members respect one another.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We share similar values and beliefs as a family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Things work well for us as a family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We really do trust and confide in each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My family members feel loyal to the family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We are proud of our family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We can express our feelings with our family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My family members like to spend free time with each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My family members feel very close to each other.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family togetherness is very important to our family.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. How often do you attend religious services?

Never /
 Once or twice a month 4

Seldom 2
 Once a week 5

A few times a year 3
 More than once a week 6

5. How important is religion in your life?

Not at all important /

Not very important 2

Somewhat important 3

Very important 6

6. Please indicate how you feel about the community of your ethnic origin.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
My ethnic community is a close-knit community.	<input type="checkbox"/>				
People in my ethnic community are willing to help each other.	<input type="checkbox"/>				
People in my ethnic community share the same values.	<input type="checkbox"/>				
People in my ethnic community generally get along with each other.	<input type="checkbox"/>				
People in my ethnic community can be trusted.	<input type="checkbox"/>				

Section 7: Life in the City of Austin

1. How long have you lived in Austin area? _____ years

2. Please indicate your rating on the following.

	Poor	Fair	Good	Excellent
The City of Austin as a place to live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The City of Austin as a place to raise children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The City of Austin as a place to work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The City of Austin as a place to build small business	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The City of Austin as a place to retire	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The City of Austin as a place to enjoy arts and culture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Safety in the City of Austin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traffic in the City of Austin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of life in the City of Austin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of services provided by the City of Austin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Below is a selected list of major city services. Please rate your satisfaction with each of the following.

	Not at all satisfied	Not very much satisfied	Pretty much satisfied	Very much satisfied	Never used
Parks and recreational services	<input type="checkbox"/>				
Libraries	<input type="checkbox"/>				
Public safety services (i.e. police, fire, and ambulance)	<input type="checkbox"/>				
Austin-Bergstrom International Airport	<input type="checkbox"/>				
Electric utility service by Austin Energy	<input type="checkbox"/>				
Municipal court services (i.e. traffic, fine collection)	<input type="checkbox"/>				
Social services/ public health services provided by the City	<input type="checkbox"/>				

4. Have you heard about the Asian American Resource Center (AARC) on Cameron Road?

Yes

No

5. How often do you visit AARC?

Never Rarely Some of the time Often

6. How often do you participate in Asian-specific activities and events in Austin?

Never Rarely Some of the time Often

7. Below is a list of questions on the city's services and resources.

◆ Do you know that Emergency Medical Services (EMS) offers a variety of free Injury prevention classes (e.g., child passenger and infant safety education, CPR training, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know that Fire Department provides free smoke detection alarms for your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know that there are free public computer training programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know that public libraries offer free access to computers and WiFi?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know that public libraries have newspapers, books and magazines in Asian languages?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know that public libraries provide free citizenship classes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know that the City offers small business assistance services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know that there are free English learning classes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know what 911 service is?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know what 311 service is?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know that Austin Police Department provides services in any language?	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Do you know which council district you are in?	<input type="checkbox"/> Yes <input type="checkbox"/> No

8. What kind of housing do you live in?

Mobile house One-family house Two-family house/duplex
 Apartment/Townhouse/Condominium Other: _____

9. Do you (and your family) own your home, rent it, or what?

Own Rent Other: _____

10. How much are you satisfied with your current housing condition?

Not at all Not very much Pretty much Very much

11. Are you willing to use a nursing home in the future? Yes No

12. Do you have smoke detection alarms in your home? Yes No

13. Do you recycle/reuse in your household? Yes No

14. Do you compost? Yes No

15. Which modes of transportation do you use on a regular basis? (Check all that apply)

Public transportation Bicycling Carpooling
 Personal car Car-share Walking Other: _____

16. What is your address and zip code? PLEASE note that this information will only be used to identify the Census tract and block codes of your residence.

Street address: _____ Zip code: _____

17. Do you have access to a computer and the Internet? Yes No

18. Do you use a cellphone, smartphone, or other mobile devices? Yes No

19. Do you have a home phone line (wired, landline)? Yes No

20. Please indicate if you have done any of the following during the past 12 months.

◆ Attended a City hosted public meeting	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
◆ Attended a City Council meeting	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ E-mailed or phoned a City official or staff person	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Voted in a City election (in the past 18 to 24 months)	<input type="checkbox"/> Yes <input type="checkbox"/> No
◆ Participated in a survey or focus groups (online or in-person) conducted by the City	<input type="checkbox"/> Yes <input type="checkbox"/> No

21. How interested are you in keeping informed about City events and City government?
 Not interested at all Not interested Somewhat interested Interested Very interested

22. In general, how satisfied are you with City government efforts to keep you informed about City services, issues, events, and programs?

Very dissatisfied Somewhat dissatisfied Neither satisfied or dissatisfied
 Somewhat satisfied Very satisfied

23. Please indicate the types of communication that you rely on to stay informed about the City of Austin.
(Check all that apply)

City-based source	Non-city-based ethnic source	Non-city-based general source
<input type="checkbox"/> Newspaper/newsletter/magazine <input checked="" type="checkbox"/>	<input type="checkbox"/> Newspaper/newsletter/magazine <input checked="" type="checkbox"/>	<input type="checkbox"/> Newspaper/newsletter/magazine <input checked="" type="checkbox"/>
<input type="checkbox"/> TV/radio station (e.g., ATXN) <input checked="" type="checkbox"/>	<input type="checkbox"/> TV/radio station <input checked="" type="checkbox"/>	<input type="checkbox"/> TV/radio station <input checked="" type="checkbox"/>
<input type="checkbox"/> Website <input checked="" type="checkbox"/>	<input type="checkbox"/> Website <input checked="" type="checkbox"/>	<input type="checkbox"/> Website <input checked="" type="checkbox"/>
<input type="checkbox"/> Social Networking Service (SNS)* <input checked="" type="checkbox"/>	<input type="checkbox"/> Social Networking Service (SNS)* <input checked="" type="checkbox"/>	<input type="checkbox"/> Social Networking Service (SNS)* <input checked="" type="checkbox"/>
<input type="checkbox"/> People (e.g., city staff) <input checked="" type="checkbox"/>	<input type="checkbox"/> People <input checked="" type="checkbox"/>	<input type="checkbox"/> People <input checked="" type="checkbox"/>
<input type="checkbox"/> Other: <input checked="" type="checkbox"/>	<input type="checkbox"/> Other: <input checked="" type="checkbox"/>	<input type="checkbox"/> Other: <input checked="" type="checkbox"/>

* e.g., Facebook, Twitter, Pinterest, Nextdoor, etc.

24. What is your most preferred type of communication for City-related information?

String

25. Please describe any concerns you may have as an Austin Resident.

String

26. Are you willing to be contacted for a follow-up to further help the City of Austin? If yes, please leave your contact information (email address or phone number) below. It will be kept strictly confidential.

String

Thank You Very Much!