ID#_____
(OFFICE USE ONLY)

Walk with Ease | Arthritis Foundation℠

Health & Demographic Survey

Baseline Questionnaire

Please complete this form and turn it in to the Christian County Health Department for your **FREE Mission to the Moon T-shirt!**
After turning in this form, you will leave with your free t-shirt along with a Walk With Ease self study guide that will teach you how to safely make physical activity a part of your every day life! A follow-up post survey will be sent to the email provided to test the effectiveness of the program. We look forward to hearing from you!

Participant ID: _____

(first 2 letters of first name, first 2 letters of last name, last 2 digits of birth year)

Date _____ Last 4 digits of your SS# _____

Name _____

Address _____

City, State, Zip _____

County _____

Telephone _____

E-Mail _____

Background

1. What is your date of birth? _____/_____/_____ Age: ____
   (month) (day) (year)

2. Are you receiving Medicare?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

3. Do you have a Medicaid FORWARD card?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

4. Who is your health insurer? _____

5. If you need to be hospitalized, what would be the hospital you would most likely use?

   _____

6. If you use a particular clinic or set of physicians, which is it?

   _____

7. What is your gender? ☐ Male ☐ Female

8. Are you Hispanic, Latino, or Spanish origin?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

9. What is your race? (**Check all that apply.**)
   - ☐ American Indian or Alaska Native
   - ☐ Asian or Asian-American
   - ☐ Black or African-American
   - ☐ Hawaiian Native or Pacific Islander
   - ☐ Hispanic
   - ☐ Bi-Racial/Multi-Racial
   - ☐ White or Caucasian
   - ☐ Other:

10. What is your current marital status? (**Check only one.**)
    - ☐ Married
    - ☐ Divorced
    - ☐ Widowed
    - ☐ Separated
    - ☐ Never married
    - ☐ Partnered (living with someone)

11. Today, how many people live in your household (including yourself)? _____

12. What is your location of residence?
    - ☐ Rural (over 10 acres)
    - ☐ Small town or village
    - ☐ City/suburb of a city

13. If you are **married or separated**, please **check** your income level **(skip if it does not apply to you)**:
    - ☐ Over $16,240
    - ☐ Under $16,240

14. If you are **widowed, divorced, never married,** or **partnered**, please **check** your income level **(skip if it does not apply to you)**:
    - ☐ Over $12,060
    - ☐ Under $12,060

15. Please circle the highest year of school you have completed:

1 2 3 4 5	6 7 8 9 10 11 12	13 14 15 16	17 18 19 20 21 22 23+
(primary)	(middle/high school)	(tech/college)	(graduate school)

16. Do you speak a language other than English at home?
    - ☐ Yes; what language? _____ (**If Yes, please answer 17 and 18**)
    - ☐ No (**If No, skip to 19**)

17. Do you sometimes have difficulty speaking English?
    - ☐ Yes
    - ☐ No

18. Do you sometimes have difficulty understanding English?
    - ☐ Yes
    - ☐ No

19. In general, would you say your health is:
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

20. Are you deaf or do you have serious difficulty hearing?
    - ☐ Yes
    - ☐ No

21. Are you blind or do you have serious difficulty seeing even with glasses?
    - ☐ Yes
    - ☐ No

22. Are you in need of care or assistance?
    - ☐ Yes
    - ☐ No

23. Do you have difficulty with daily activities such as eating, bathing, dressing, toileting, transferring (ie; walking, moving from a seated position to standing), or continence?
    - ☐ Yes
    - ☐ No

24. Did a Health Care Professional refer you to this program?
    - ☐ Yes
    - ☐ No

25. Has a health care provider ever told you that you have any of the following chronic conditions? (**Check all that apply.**)

- ☐ Alzheimer's or Related Dementia
- ☐ Arthritis/Rheumatic Disease
- ☐ Stroke
- ☐ Depression or Anxiety Disorders
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Breathing/Lung Disease (*Asthma, Emphysema, Bronchitis*)
- ☐ Schizophrenia/Psychotic Disorder
- ☐ Other Chronic Condition(s): *Please list here:* _____
- ☐ Hypertension (high blood pressure)
- ☐ Osteoporosis (low bone density)
- ☐ Cancer or Cancer Survivor
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Obesity
- ☐ Stroke
- ☐ None

26. When you need some help with things around the house, do you have someone you can count on to help?

- ☐ Yes (**If Yes, please answer the next question**)
- ☐ No (**If No, skip to Question 28**)

27. Who provides the **most** help for you? **(Check only one.)**

- ☐ Spouse in house
- ☐ Child in home
- ☐ Other family in home
- ☐ Other in home
- ☐ Child out of home
- ☐ Other family out of home
- ☐ Other out of home
- ☐ Don't know

28. Are you limited in any way in any activities because of physical, mental or emotional problems?

- ☐ Yes
- ☐ No

29. Are you currently or in the last year have you been a caregiver for a family member or friend?

- ☐ Yes
- ☐ No

30. What is your confidence level in managing chronic (on-going health) symptoms? *(Leave blank If this does not apply.)*

1 2 3 4 5 6 7 8 9 10
(please circle one)

31. What is your confidence level in managing arthritis symptoms? *(Leave blank if this does not apply.)*

1 2 3 4 5 6 7 8 9 10
(please circle one)

32. How many days per week do you walk? _____

33. How many minutes each of those days do you walk? _____

34. How did you learn about this Workshop? (Check all that apply)

- ☐ Friend or family member
- ☐ TV or Radio
- ☐ Poster or Brochure
- ☐ Presentation
- ☐ Newspaper/Newsletter
- ☐ Other
- ☐ Doctor recommendation
- ☐ Other health care provider