New Jersey Department of Health
Office of Minority and Multicultural Health

CHRONIC DISEASE SELF-MANAGEMENT PROGRAM

"TAKE CONTROL OF YOUR HEALTH"
PRE-WORKSHOP PARTICIPANT SURVEY

ID Number: _____ Date: _____ Zip Code: _____

Sex *(Check)*: ☐ Female ☐ Male

What is your age group?

☐ Under 25
☐ 25 - 34
☐ 35 - 44
☐ 45 - 54
☐ 55 - 64
☐ 65+

Are you Hispanic, Latino/a, or Spanish origin?
(One or more categories may be selected.)

a. ☐ Mexican, Mexican American, Chicano/a
b. ☐ Puerto Rican
c. ☐ Cuban
d. ☐ Another Hispanic, Latino, or Spanish origin

What is your race?
(One or more categories may be selected)

a. ☐ White
b. ☐ Black or African American
c. ☐ American Indian or Alaska Native
d. ☐ Asian Indian
e. ☐ Chinese
f. ☐ Filipino
g. ☐ Japanese
h. ☐ Korean
i. ☐ Vietnamese
j. ☐ Other Asian
k. ☐ Native Hawaiian
l. ☐ Guamanian or Chamorro
m. ☐ Samoan
n. ☐ Other Pacific Islander

Are you currently:
(check only one)

☐ Married
☐ Single
☐ Separated
☐ Divorced
☐ Widowed
☐ Partnered (living with someone)

What level of education did you complete?
(check only one)

☐ Less than high school
☐ Some high school
☐ High school graduate
☐ Some college or vocational school
☐ College graduate
☐ Graduate school

How well do you speak English? *(check only one)*

☐ Very well ☐ Well ☐ Not well ☐ Not at all

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Has a doctor or nurse ever told you that you are sick because you have:
(Mark all that apply.)

- ☐ Arthritis/Rheumatic Disease
- ☐ Breathing/ Lung Disease (e.g., Asthma, Emphysema, Bronchitis)
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hypertension (High Blood Pressure)
- ☐ Cancer
- ☐ Stroke
- ☐ Depression or Anxiety Disorder
- ☐ Osteoporosis
- ☐ Other Chronic Condition: _____
- ☐ None (No Chronic Conditions)

I. In general, would you say your health is: *(check one)*

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

II. Daily Activities		***(Circle one)***				
		Not at all	**Slightly**	**Moderately**	**Quite a bit**	**Almost totally**
1	**During the past 2 weeks,** how much has your sickness stopped you from being with family, friends, neighbors or groups?	**0**	**1**	**2**	**3**	**4**
2	**During the past 2 weeks,** how much has your sickness stopped you from doing things you enjoy like reading, playing sports or other fun things?	**0**	**1**	**2**	**3**	**4**
3	**During the past 2 weeks,** how much has your sickness stopped you from doing everyday work around your house (e.g. cleaning, cooking etc.)?	**0**	**1**	**2**	**3**	**4**
4	**During the past 2 weeks,** how much has your sickness stopped you from doing other things that you need to do such as shopping?	**0**	**1**	**2**	**3**	**4**

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III. Controlling My Sickness For each of the following questions, please ***circle one*** number for each question that tells how you feel about doing things easily at this time:		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1	Feeling tired from being sick does not stop me from doing things that I want to do.	**1**	**2**	**3**	**4**	**5**
2	Feeling pain, aches, or hurting from being sick does not stop me from doing things I want to do.	**1**	**2**	**3**	**4**	**5**
3	Feeling upset, sad, or crying from being sick does not stop me from doing things I want to do.	**1**	**2**	**3**	**4**	**5**
4	Feeling any other signs of sickness or health problems (aches, pains, or being sad) does not stop me from doing things I want to do.	**1**	**2**	**3**	**4**	**5**
5	I can do things I need to do to control my sickness so that I don't go to the ER or ask to see my doctor.	**1**	**2**	**3**	**4**	**5**
6	I can do things other than just take a pill to stop my sickness from being a problem every day.	**1**	**2**	**3**	**4**	**5**

IV. During the past week I was able to stretch, walk, swim, bike, or do other types of exercise for: *(check only one)*

- ☐ None
- ☐ Less than 30 minutes/week
- ☐ 30 - 60 minutes/week
- ☐ 1 – 3 hours/week
- ☐ More than 3 hours/week

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V. Medical Care When you **go to your doctor**: *(please circle one number for each question)*		*(Circle one)*					
		Never	**Almost never**	**Some-times**	**Fairly often**	**Very often**	**Always**
1	Do you make a list of questions for your doctor?	**0**	**1**	**2**	**3**	**4**	**5**
2	Do you ask questions about the things you want to know and things you don't understand?	**0**	**1**	**2**	**3**	**4**	**5**
3	Do you talk about things other than your being sick?	**0**	**1**	**2**	**3**	**4**	**5**

4	In the past 2 months, how many TIMES did you visit a doctor? *(Do **not** include hospital or ER visits)*	_____ **times**
5	In the past 2 months, how many TIMES did you go to a walk-in-clinic for an emergency?	_____ **times**
6	In the past 2 months, how many TIMES did you go to a hospital emergency room?	_____ **times**
7	In the past 2 months, how many TIMES were you admitted to the hospital for one night or longer?	_____ **times**

VI. Check all that apply:

I am a member with a sickness. ☐ Yes ☐ No

I take care of someone with a sickness. ☐ Yes ☐ No

VII. Have you ever taken this class before?

☐ Yes ☐ No ☐ Unsure

VIII. This survey was completed: *(check only one)*

☐ Without help ☐ With some help

Thank you for completing the survey!