COMMUNITY SERVICES, INC. OF OCEAN COUNTY

TAKE CONTROL OF YOUR HEALTH

CHRONIC DISEASE & DIABETES SELF-MANAGEMENT WORKSHOPS

WORKSHOP REGISTRATION

A. PARTICIPANT INFORMATION

Name: _____
Last **First** **Middle Initial**

Street Address: _____ Apt. # _____

City / Town: _____ Borough / Township: _____

State: ~~NJ~~ Zip Code: _____

Phone: _____ Cell Phone: _____

E-mail Address: _____

Date of Birth: _____ **60 or older?** ◯ Yes ◯ No
(MM / DD / YY)

Is your <u>monthly</u> income …?

Single:	$1,073	◯ Below	◯ Above
Married:	$1,452	◯ Below	◯ Above

B. EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

Phone: _____ Cell Phone: _____

C. WORKSHOP LOCATION

Workshop Location: _____

Date: _____

Take Control of Your Health

Participant Information Survey

Instructions:

Please answer the questions on both pages of this form.

Please click boxes to mark your selections with a check mark.

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 Alaska Native
   ☐ Asian
   ☐ Black or African-American
   ☐ Native Hawaiian or Other Pacific Islander
   ☐ White

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

   ☐ Alzheimer's or Related Dementia
   ☐ Arthritis/Rheumatic Disease
   ☐ Asthma/Emphysema/Other Chronic Breathing or Lung Problem
   ☐ Cancer or Cancer Survivor
   ☐ Chronic Pain
   ☐ Depression or Anxiety Disorders
   ☐ Diabetes
   ☐ Heart Disease
   ☐ High Cholesterol
   ☐ Hypertension (High Blood Pressure)
   ☐ Kidney Disease
   ☐ Obesity
   ☐ Osteoporosis (Low Bone Density)
   ☐ 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

Participant Information Survey (Continued)

Participant ID | | | | | | |

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

11. What is the highest grade or year of school you completed?

◯ Some elementary, middle or high school
◯ High school or GED
◯ Some college or technical school
◯ College 4 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 health care provider suggest that you take this program?

◯ Yes ◯ No

TO BE COMPLETED AT LAST PROGRAM SESSION

Please circle the number that best matches how confident you are feeling.

14. After taking this workshop, I am more confident that I can manage my chronic condition(s).

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

SUBMIT