Illinois Pathways to Health by AgeOptions

Take Charge Pre-Survey
Participant Information Form

Participant Number or Name: _____

Participant Date of Birth: __ __ / __ __ / __ __ (e.g., 12/01/21)

Workshop ID: __ __ (e.g., 01, 02, 03, etc.)

Provider Name: _____ (e.g., XYZ Organization)

Start date of program: __ __ / __ __ / __ __ (e.g., 12/01/21)

Program Name:

☐ Take Charge of Your Health ☐ Take Charge of Your Pain ☐ wCDSMP
☐ Take Charge of Your Diabetes ☐ Cancer: Thriving and Surviving

How did you hear about this class?

☐ Physician or member of my healthcare team ☐ Care Coordinator
☐ Insurance Company ☐ Family member/friend
☐ Community Organization ☐ Other: _____

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1. Did your doctor of other health care provider suggest that you attend this program?
   ☐ Yes ☐ No

2. From what health system do you receive your primary healthcare care services?

Advocate Aurora Health		Mercy Health Corporation	
Amita Health		NorthShore University Health System	
Blessing Health System		Northwestern Memorial Health Care	
Carle Health		OSF Health Care	
Cook County Health		Presence Health	
Edward-Elmhurst Health		Rush	
Hospital Sisters Health System		Sinai Chicago	
Kindred Healthcare		Southern Illinois Healthcare	
Loyola Medicine		Swedish American Health System	
Memorial Health System			

3. How old are you today? ☐☐ years

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4. How would you describe your gender?

☐	Male
☐	Female
☐	Genderqueer/Gender Non-Conforming
☐	Trans Male/Trans Man
☐	Trans Female/Trans Woman
☐	Not listed above Please specify: _____
☐	Decline to answer

5. What sex were you assigned at birth, such as on an original birth certificate?

☐	Male
☐	Female
☐	Intersex
☐	Decline to answer

6. Sexual orientation:

☐	Lesbian
☐	Gay
☐	Bisexual
☐	Queer
☐	Straight
☐	Something else
☐	Questioning
☐	Decline to answer

7. Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

8. What is your race? **Check all that apply.**

☐	American Indian or Alaska Native
☐	Asian
☐	Black or African American
☐	Native Hawaiian or other Pacific Islander
☐	White

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

10. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
☐ Yes ☐ No

11. Do you live alone? ☐ Yes ☐ No

12. 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)

13. Have you ever served in the military? ☐ Yes ☐ No

14. 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

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15. In general, would you say that your health is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

16. Has a health care provider ever told you that you have any of the following chronic conditions?

	YES	NO		YES	NO
Anxiety Disorder	☐	☐	Chronic Pain	☐	☐
High Cholesterol	☐	☐	Kidney Disease	☐	☐
Asthma/Emphysema/Other Chronic Breathing or Lung Problem	☐	☐	Osteoporosis (Low Bone Density)	☐	☐
Cancer or Cancer Survivor	☐	☐	Obesity	☐	☐
Hypertension (High Blood Pressure)	☐	☐	Schizophrenia or Other Psychotic Disorder	☐	☐
Depression	☐	☐	Stroke	☐	☐
Diabetes (High Blood Sugar)	☐	☐	Arthritis/Rheumatic Disease	☐	☐
Heart Disease	☐	☐	Other Chronic Condition	☐	☐

17. Because of a physical, mental, or emotional condition, do you:
   - Have serious difficulty concentrating, remembering, or making decisions?
     ☐ Yes ☐ No
   - Have difficulty doing errands alone such as visiting a doctor's office or shopping?
     ☐ Yes ☐ No

18. Do you have serious difficulty walking or climbing stairs? ☐ Yes ☐ No

19. Do you have difficulty dressing or bathing? ☐ Yes ☐ No

20. How often do you feel lonely or isolated from those around you?
☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

21. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Totally sure

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22. The UCLA 3-item Loneliness scale:

	Hardly ever	Some of the time	Often
a. How often do you feel that you lack companionship?	☐	☐	☐
b. How often do you feel left out?	☐	☐	☐
c. How often do you feel isolated from others?	☐	☐	☐

23. In general, I would say that my sense of well-being is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

24. Please provide any other information you would like us to know:

_____

_____

_____