**Remote Implementation of**

**Chronic Pain Self-Management Program (CPSMP)**

**Participant Information**

Thank you for taking a few minutes to answer some brief questions. While you may leave any question blank, we encourage you to complete the entire survey. Information from the survey will help us show how this program is serving people who benefit the most. Your responses are very helpful.

This survey asks for basic information. Your responses are confidential and will not affect any services or programs that you may be receiving. If you have any questions, please ask the class facilitator.

***First* name/nickname:**

**1. What is your age?**

**2. What is your gender?** [ ] Female [ ] Male

**3**. **Marital Status** [ ] Single [ ] Partnered [ ] Married [ ] Divorced [ ] Widowed

**4. What is your Zip Code?**

**5. What is your race?** *(Please mark all that apply)*

|  |  |
| --- | --- |
|[ ]  Asian or Asian-American |[ ]  Native American or Alaska Native |
|[ ]  Black or African American |[ ]  White or Caucasian |
|[ ]  Hispanic or Latino |[ ]  Other:  |

**6. 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 |[ ]  Heart Disease |
|[ ]  Arthritis/Rheumatic Disease |[ ]  High Cholesterol |
|[ ]  Breathing/Lung Disease(Asthma, COPD) |[ ]  High Blood Pressure (hypertension) |
|[ ]  Cancer |[ ]  Kidney Disease |
|[ ]  Chronic Pain |[ ]  Osteoporosis (low bone density) |
|[ ]  Depression/Anxiety Disorders |[ ]  Obesity |
|[ ]  Diabetes |[ ]  None (no chronic conditions)  |
|[ ]  Mental Health Condition (Bipolar, Schizophrenia, etc.) |[ ]  Other:  |

**7. Do you provide regular care or assistance to a friend or family member who has a chronic health condition or disability?**

 [ ] Yes [ ] No

**8. Do you have any of the following?**

a) Hearing Impairment? [ ] Yes [ ] No

 b) Visual Impairment (glaucoma, macular degeneration, etc.)? [ ] Yes [ ] No

 c) Limited in daily activities due to physical, mental, or emotional issues? [ ] Yes [ ] No

**9. How many people live in your household including yourself?**

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

|  |  |
| --- | --- |
|[ ]  8th grade or less |[ ]  Some college or technical school |
|[ ]  Middle or some high school |[ ]  Bachelor’s degree |
|[ ]  High school graduate or GED |[ ]  Master’s or professional degree |

**11. How would you rate your health?**

[ ]  Excellent [ ]  Good [ ]  Fair [ ] Poor

**12. What type of health insurance do you have?** (*Please mark all that apply*)

|  |  |
| --- | --- |
|[ ]  Medicaid |[ ]  Private Insurance |
|[ ]  Medicare (Red, White, Blue card)  |[ ]  I don’t have insurance |
|[ ]  Medicare Advantage Plan (Aetna, Anthem, etc.) |[ ]  Other: Click or tap here to enter text. |

**13. How did you hear about the Chronic Pain Self-Management Program Workshop?**

|  |  |
| --- | --- |
|[ ]  A friend or family member |[ ]  Attending another educational event |
|[ ]  Retirement system or health plan |[ ]  Place of faith (temple, mosque, church) |
|[ ]  Area Agency on Aging |[ ]  Flyer, email or mailing |
|[ ]  Doctor’s office or healthcare provider |[ ]  Health Fair |
|[ ]  Senior Center |[ ]  Other: Click or tap here to enter text. |

*Thank You!*