

CWD - Workshop Data

Workshop Details

Which staff member is completing this form? *

Allison Goforth
Ean Hodge
Melissa Reynosa
Natalie Padilla
Mayra Rodriguez
Frank Moreno
Christina Camargo
Mayte Villanueva

Workshop type

*

CDSMP
TOMANDO
DSMP

Please select the **state** where workshop is being provided

California

Class type *

A dropdown menu with a white background and a grey border. It contains the text "Virtual" and "Telephonic". To the right of the text is a vertical scrollbar with a checkered pattern. The menu is currently open, showing the options.

Language

A dropdown menu with a white background and a grey border. It contains the text "English" and "Spanish". To the right of the text is a vertical scrollbar with a checkered pattern. The menu is currently open, showing the options.

What is the start date of the workshop you are participating in? *

Write-in the start date **without** the dashes (ex: if the start date is April 16, 2020, you would write 041620)

ex: 041620

What is your group number/letter? *

A small, empty rectangular text input field with a grey border.

Client Intake - Confidential

Contact Information

First Name

Last Name

Street Address

Apt/Unit #

City

State

Zip

Phone Number

Date of birth

Please enter the full **date** of birth



Not provided

☐

The participant does not want to provide their full
DOB

What language do you speak at home?

Ethnicity Information

- | | | |
|---|---|---|
| <input type="checkbox"/> Multiple race | <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Declined to state |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> White/Caucasian | <input type="checkbox"/> Other, please specify: |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Native American/Alaskan Native | <input type="text"/> |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Unknown | |

Income Information

Number of household members

member(s)

Total Household Income

☐ \$0 - \$4,870/month (\$58,450/year)

☐ Declined to state

☐ \$_____/ per year

Health Insurance Information

Do you have health insurance?

- ☐ Yes ☐ No

Insurance Provider

- ☐ Blue Cross/Blue Shield
☐ United Healthcare
☐ Care First
☐ Aetna
☐ HealthNet
☐ Assurant
☐ Humana
☐ Cigna
☐ AARP
☐ Other
☐ Kaiser Permanent

CDSME Session 1 Survey

1. Did your doctor or other health care provider suggest that you attend this program?

- ☐ Yes
☐ No

2. How old are you today?

years

3. Are you male or female?

- ☐ Male
☐ Female

4. Are you of Hispanic, Latino, or Spanish origin?

- ☐ Yes
☐ No

5. What is your race? Mark all that apply.

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White |
| <input type="checkbox"/> Black or African American | |

6. Are you deaf or do you have serious difficulty hearing?

- ☐ Yes ☐ No

7. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- ☐ Yes ☐ No

8. Do you live alone?

- ☐ Yes ☐ No

9. 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

10. Have you ever served in the military?

- ☐ Yes
- ☐ No

11. 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

12. In general, would you say that your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

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

	Yes	No
Anxiety disorder	<input type="radio"/>	<input type="radio"/>
Chronic pain	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>
Kidney disease	<input type="radio"/>	<input type="radio"/>
Asthma/Emphysema/Other Chronic Breathing or Lung Problem	<input type="radio"/>	<input type="radio"/>
Osteoporosis (Low Bone Density)	<input type="radio"/>	<input type="radio"/>
Cancer or Cancer Survivor	<input type="radio"/>	<input type="radio"/>
Obesity	<input type="radio"/>	<input type="radio"/>
Hypertension (High Blood Pressure)	<input type="radio"/>	<input type="radio"/>
Schizophrenia or other psychotic disorder	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>
Diabetes (High Blood Sugar)	<input type="radio"/>	<input type="radio"/>
Arthritis/Rheumatic Disease	<input type="radio"/>	<input type="radio"/>
Heart Disease	<input type="radio"/>	<input type="radio"/>
<input type="text" value="Enter another option"/>	<input type="radio"/>	<input type="radio"/>

14. Do you have serious difficulty walking or climbing stairs?

☐ Yes ☐ No

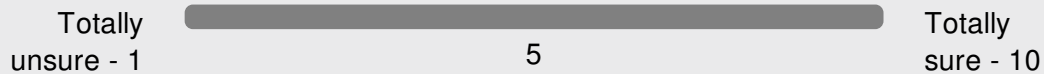
15. Do you have difficulty dressing or bathing?

- ☐ Yes ☐ No

16. How often do you feel lonely or isolated from those around you?

- ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

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



18. Are you on Medi-Cal?

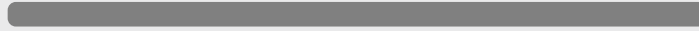
- ☐ Yes ☐ No ☐ I don't know

19. During the past week, how much has your health interfered with your normal activities with family, friends, neighbors or groups?

- ☐ Always ☐ Usually ☐ Half of the time ☐ Occasionally ☐ Never

20. In the past week, how many days did you exercise for at least 30 minutes?

0 days



7 days

21. Please select one answer for each statement below:

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	I don't know
I am content with my friendships and relationships	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have enough people I feel comfortable asking for help at any time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My relationships are as satisfying as I would want them to be	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Participant ID

Page description:

Please write this information down for your reference.

Please write down your "Participant ID" below

[question('option value'), id='80', option='10195'] [question('value'), id='90'] [question('value'), id='87']

Please write down your "Participant ID" below

[question('option value'), id='80', option='10195'] [question('value'), id='154'] [question('value'), id='155']