DIABETES SELF-MANAGEMENT

Participant Registration Form

Today's Date: ____________

Please Print Clearly

Name:		
Home Phone: ( )	Cell Phone: ( )	Work Phone: ( )
Street Address:		
City:	State:	Zip Code:
Email:		
Date of Birth:		

How did you hear about this class?	
( )	Physician
( )	Family Member or Friend
( )	Church
( )	Newspaper, flyer or mailing
( )	Neighbor
( )	Activities Director where I live
( )	Senior Center
( )	Other - please specify

Have you ever participated in a Diabetes Self-Management Workshop?	
( )	Yes, if "yes" specify the year
( )	No
( )	Uncertain

Q1 What is your age?	
( )	Below 60
( )	60 or over
Q2 What is your Zip Code?	
Q3 Today, how many people live in your household (including yourself?	
Q4 What is your gender?	
( )	Male
( )	Female
Q5 Are you Hispanic, Latino or of Spanish origin?	
( )	Yes
( )	No
( )	Not sure
Q6 Please select one or more of the following that bests describes your race and ethnicity:	
( )	American Indian or Alaska Native
( )	Asian or Asian American
( )	Black or African American
( )	Hawaiian Native or Pacific Islander
( )	White/Caucasian
( )	Other - specify
Q7 What is the highest level of education you have completed?	
( )	Less than high school
( )	High school graduate or GED
( )	Some college or technical school
( )	College/university graduate
( )	Graduate school
Q8 Do you speak a language other than English at home?	
( )	Yes, if yes what other language(s) do you speak?
( )	No
Q9 Do you have difficulty reading or understanding English?	
( )	Yes
( )	No

Q10	Please indicate what chronic or ongoing health conditions you have:
( )	Acid Reflux/Chronic Heartburn
( )	Alzheimer's or Related Dementia
( )	Anxiety Disorder
( )	Arthritis
( )	Breast Cancer
( )	Cervical Cancer
( )	Chronic Pain
( )	Colorectal Cancer
( )	Depression
( )	Epilepsy
( )	Heart Attack
( )	Heart Disease
( )	Hepatitis
( )	High Cholesterol
( )	HIV/AIDS
( )	Hypertension/High Blood Pressure
( )	Irritable Bowel Syndrome
( )	Kidney Disease
( )	Kidney Stones
( )	Lung Cancer
( )	Lung Disease (Asthma, Bronchitis, Emphysema)
( )	Mental Illness
( )	Metabolic Syndrome
( )	Multiple Sclerosis
( )	Obesity
( )	Osteoporosis (Low Bone Density)
( )	Ovarian Cancer
( )	Parkinson's Disease

( )	Pre-Diabetes
( )	Prostate Cancer
( )	Skin Cancer
( )	Stroke
( )	Type 1 Diabetes
( )	Type 2 Diabetes
( )	Other – please list all that apply
( )	I do not know if I have a chronic illness
( )	I do not have a chronic illness
Q11	What is your current marital status?
( )	Married
( )	Divorced
( )	Widowed
( )	Separated
( )	Never married
( )	Partnered (living with someone)
Q12	Do you have any health insurance?
( )	Yes
( )	No
Q13	If "Yes" to question 12, what is your health insurance? Please check all that apply.
( )	Medicare (Original Medicare)
( )	Medicare Supplement
( )	Medicare Advantage Plan
( )	Medicaid
( )	Private Insurance
( )	Veterans
( )	Unsure
Q14	What is your annual (yearly) income?
( )	Below $11,770
( )	Below $14,713
( )	Below $15,930

( )	Below $19,913
( )	Above $25,000
Q15 Are you a caregiver for a family member or friend?	
( )	Yes
( )	No
Q16 How often do you socialize (spend time) with family and/or friends?	
( )	More than five (5) times a week
( )	Two (2) or more times a week
( )	Less than once a week
Q17 Do you need assistance with two (2) or more Activities of Daily Living? (For example, bathing, dressing, walking, eating, getting out of bed or chair or using the bathroom)	
( )	Yes
( )	No

PLEASE INDICATE WHETHER YOU WOULD LIKE TO BE ADDED TO OUR EMAIL LIST TO BE NOTIFIED OF CLASSES.

____ YES, PLEASE ADD MY EMAIL TO YOUR LIST

____ NO, I AM NOT INTERESTED IN BEING ADDED TO YOUR EMAIL LIST.

THANK YOU AND ENJOY YOUR CLASS !