NACCHO Health Promotion Survey

Please circle your answers to each question.

1. **Do you have any of the following <u>long-lasting conditions</u>?**

   a) Blindness or a severe vision impairment Yes No Don't know

   b) Deafness or a severe hearing loss Yes No Don't know

   c) A condition that greatly limits one or more basic physical activities such as walking, climbing stairs, reaching, lifting or carrying? Yes No Don't know

   d) A recurring condition that limits your ability to conduct basic daily activities? Yes No Don't know

   e) A mental health condition that limits your ability to conduct basic daily activities? Yes No Don't know

   f) A disability that limits functioning such as learning, understanding or processing information? Yes No Don't know

2. **Do you have any difficulties doing any of the following activities because of a physical, mental, or emotional condition that has lasted six months or longer?**

   a) Dressing, bathing, or getting around inside your home?
   Yes No

   b) Going outside the home alone to shop or visit a doctor's office?
   Yes No

   c) Working at a job or business?
   Yes No

   d) Learning, remembering, or concentrating?
   Yes No

If you answered "**no" to all the questions so far,** please stop now and give this survey to the staff person who gave it to you. Thank you for your time.


If you answered "**yes" to at least one of the questions so far**, please continue.

3. How would you name your disability/ies or impairment

_____

4. Where do you <u>want</u> to get information about taking care of your health?

Doctor/health care provider	Yes	No	Don't know
Case manager/social worker	Yes	No	Don't know
Family	Yes	No	Don't know
Friends	Yes	No	Don't know
Coworkers	Yes	No	Don't know
Church/ faith community	Yes	No	Don't know
Neighbors	Yes	No	Don't know
Books	Yes	No	Don't know
Internet	Yes	No	Don't know
TV	Yes	No	Don't know
Support Group	Yes	No	Don't know
Social services	Yes	No	Don't know
School	Yes	No	Don't know
Other_____	Yes	No	Don't know

5. **In what format would you like to receive information about taking care of your heath?**

Written materials	Yes	No	Don't know
CDs or audio tape	Yes	No	Don't know
Videos/DVDs	Yes	No	Don't know
Large print	Yes	No	Don't know
Brail	Yes	No	Don't know
Electronic/Internet	Yes	No	Don't know
Other_____	Yes	No	Don't know

6. **Are you satisfied with the information you are getting from your doctor or health care provider?** Yes No Don't know

Please explain:

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7. **Would you like to get more information from your doctor or health care provider?** Yes No Don't know

If you answered "no" to question 7, skip to question 9.

8. **What information would you like to get from your doctor or heath care provider?**

_____

9. **Are you satisfied with the treatment you receive from your doctor or health care provider?**

Yes No Don't know

Please explain:

_____

10. What health promotion <u>activities</u> would you be interested in?

Leisure/stress reduction	Yes	No	Don't know
Health education classes	Yes	No	Don't know
Exercise classes	Yes	No	Don't know
Cooking or nutrition classes	Yes	No	Don't know
Social groups	Yes	No	Don't know
Religious/spiritual activities	Yes	No	Don't know
Recreational activities	Yes	No	Don't know
Other_____	Yes	No	Don't know

11. What health promotion <u>supports</u> would you be interested in?

Help setting up your home	Yes	No	Don't know
Home devices/aids	Yes	No	Don't know
Job training or help on how to manage money	Yes	No	Don't know
Help arranging transportation	Yes	No	Don't know
Reminders for medical checkups	Yes	No	Don't know
Other_____	Yes	No	Don't know

12. What health promotion <u>information</u> would you be interested in?

Information about accessible services	Yes	No	Don't know
Information about accessible outdoor trails or other exercise activities	Yes	No	Don't know
Information about alternative treatments	Yes	No	Don't know
Resources lists	Yes	No	Don't know
Other_____	Yes	No	Don't know

13. People sometimes have problems doing what they want to do to stay healthy. Please tell us how often each of these problems keeps you from taking care of your health. (please circle)

Lack of convenient facilities	Never	Sometime	Often	Always
Too tired	Never	Sometime	Often	Always
Lack of transportation	Never	Sometime	Often	Always
Feeling what I do doesn't help	Never	Sometime	Often	Always
Lack of money	Never	Sometime	Often	Always
Impairment	Never	Sometime	Often	Always
No one to help me	Never	Sometime	Often	Always
Not interested	Never	Sometime	Often	Always
Lack of information about what to do	Never	Sometime	Often	Always
Embarrassment about my appearance	Never	Sometime	Often	Always
Concern about safety	Never	Sometime	Often	Always
Lack of support from family/friends	Never	Sometime	Often	Always
Interferes with other responsibilities	Never	Sometime	Often	Always
Lack of time	Never	Sometime	Often	Always
Feeling I can't do things correctly	Never	Sometime	Often	Always
Difficulty with communication	Never	Sometime	Often	Always
Bad weather	Never	Sometime	Often	Always
Lack of help from heath care professionals	Never	Sometime	Often	Always
Lack of disability accommodation and/or access	Never	Sometime	Often	Always
Other_____	Never	Sometime	Often	Always

14. Do you have a nurse case manager or a social worker at this clinic? Yes No Don't know

15. What year were you born? _____

16. What is your gender? (Please circle or fill in the blank.)

Female Male Other_____

17. What is your race/ethnicity? (Circle all that apply or fill in the blank.)

African American/Black White/Caucasian Hispanic/Latino

Asian/Pacific Islander American Indian/Alaskan Native Other_____

18. Would you like the Health Department to let you know about health promotion activities, information and support when these become available?

Yes No

19. Would you be interested in sharing your opinions/thoughts and/or becoming involved with future planning of health promotion activities for people with disabilities?

Yes No

20. If you answered yes to either question 18 or 19, please provide your contact information. <u>We will only use your information for what you said "yes" to</u>.

Name _____

Address _____

_____

Phone Number _____

E-mail Address _____

Thank you very much for completing our survey!