Walk With Ease Program Registration

First and Last Name:

Phone Number:

Email Address:

Did your doctor or other health care provider suggest that you attend this program?
a. Yes
b. No

How old are you today? _____ years old

What is your gender?
a. Male
b. Female
c. Transgender
d. Other/prefer not to respond

Are you of Hispanic, Latino, or Spanish origin?
a. Yes
b. No
c. Unknown

What is your race? *Mark all that apply.*
a. American Indian or Alaska Native
b. Asian
c. Black or African American
d. Native Hawaiian or other Pacific Islander
e. White

Are you deaf or do you have serious difficulty hearing?
a. Yes
b. No

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

Do you live alone?
a. Yes
b. No

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

a. Some elementary, middle, or high school
b. High school graduate or GED
c. Some college or technical school
d. College 4 years or more

Have you ever served in the military?

a. Yes
b. No

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?

a. Yes
b. No

In general, would you say your health is:

a. Excellent
b. Very Good
c. Good
d. Fair
e. Poor

Has a health care provider ever told you that you have any of the following chronic conditions? *Mark an 'X' in the column next to all that apply (continued on next page)*

Anxiety Disorder	
Arthritis/Rheumatic Disease	
Asthma/Emphysema/Other Chronic Breathing or Lung Problem	
Cancer or Cancer Survivor	
Chronic Pain	
Depression	
Diabetes (High Blood Sugar)	
Heart Disease	
High Cholesterol	
Hypertension (High Blood Pressure)	
Kidney Disease	
Obesity	
Osteoporosis (Low Bone Density)	

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Pre-Diabetes	
Schizophrenia or Other Psychotic Disorder	
Stroke	
Other (please specify):	

Because of a physical, mental, or emotional condition, do you (*Mark all that apply):*

a. Have serious difficulty concentrating, remembering, or making decisions?
b. Have serious difficulty doing errands alone such as visiting a doctor's office or shopping?
c. Have serious difficulty walking or climbing stairs?
d. Have serious difficulty dressing or bathing?

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

a. Always
b. Often
c. Sometimes
d. Rarely
e. Never

How sure are you that you can manage your condition(s) so you can do the things you need and want to do? *(Circle an option)*

0	1	2	3	4	5	6	7	8	9	10
(Totally unsure)										(Totally sure)

Where did you hear about the program? *Mark all that apply.*

a. I was referred by my doctor or other medical provider
b. I heard about it from friends or family
c. This is a benefit offered through my health insurance (if yes, please name health insurance plan:_____)
d. I responded to an advertisement or invitation from a local organization (if yes, please name the organization:_____)
e. I heard about it through social media (e.g. Facebook, Twitter, Instagram)
f. Other (please describe):_____

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Which of the following best describes your health insurance coverage?

a. Medicare (Original)
b. Medicare Advantage Plan (HMO, PPO, Medical Savings Account)
c. Medicare Advantage Plan (Special Needs Plans, including Dual-Eligible SNP)
d. Medicaid (Oregon Health Plan)
e. Employer or Union-based Health Insurance
f. Veteran's Health Care Benefits/Coverage
g. Veteran's Health System
h. TRICARE/TRICARE for Life
i. Indian Health Services
j. No insurance
k. Other insurance (please describe):_____

In what county do you currently live? _____

In what ZIP Code do you currently live? _____

How many days during a typical week do you go for a walk/s?

a. 1
b. 2
c. 3
d. 4
e. 5
f. 6
g. 7

On average, how many minutes do you walk on **each** of those days? _____ minutes

Have you participated in the Walk With Ease program in the past?

a. Yes
b. No
c. I don't know

Thank you for your time in completing this form!