UTAH DEPARTMENT OF HEALTH
Utah Arthritis Program

LIVING WELL WORKSHOP
PARTICIPANT INFORMATION FORM

Please clearly print the information below

Please print your initials and number #	Birth Date (month/day/year): / /	What is your zip code?

What is your sex?
☐ Male ☐ Female

Are you of Hispanic, Latino, or Spanish Origin?
☐ Yes ☐ No ☐ Unknown

What is your race? (***Check all that apply***)

☐ American Indian
☐ Asian/Asian American
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ White

Has a health care provider ever told you that you have any of the following chronic conditions?
PLEASE CHECK ALL THAT APPLY.

☐ Alzheimer's/Dementia	☐ Cancer/Cancer Survivor	☐ Emphysema	☐ Kidney Disease
☐ Arthritis	☐ Chronic Pain	☐ Fibromyalgia	☐ Lung Cancer
☐ Asthma/Breathing	☐ Chronic Joint Pain	☐ Heart Disease	☐ Multiple Sclerosis
☐ Bronchitis	☐ Depression or Anxiety	☐ High Cholesterol	☐ Osteoporosis
☐ COPD	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ None (***No chronic conditions***)	☐ Other condition(s): _____		

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

Are you limited in any way in any activities due to a physical, mental, or emotional problem?
☐ Yes ☐ No

Today, how many people live in your household, including yourself? (***Number of people***)

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

☐ Less than High School
☐ Some College or Technical School
☐ High School Graduate or GED
☐ Bachelor's Degree or higher

Do you now use tobacco (***cigarettes, cigars, or smokeless tobacco***)?
☐ Every day ☐ Some day's ☐ Not at all