Chronic Pain Self-Management Education Workshop Registration

All information will be kept confidential.

First Name _____ **Last Name** _____

Address _____

City _____ **Zip** _____ **County** _____

Phone Number _____ **Email** _____

My Doctor's Name _____

My Doctor's Office Name _____

My Doctor's City/Town _____

How did you hear about class? *(Please check all that apply)*

- ☐ Senior Center
- ☐ The building where I live
- ☐ Ad in magazine or newspaper
- ☐ My doctor
- ☐ Church
- ☐ Other (tell us what) _____
- ☐ A friend or family member
- ☐ Poster, flier, or mailing

Gender ☐ Male ☐ Female **Birth Date** _____
(Month, Day, Year) Example: 01/16/1965

Please identify your race *(optional)*

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Other _____

Please identify your ethnicity *(optional)*

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Do you speak a language other than English at home?

☐ Yes ☐ No If yes, what language _____

Please Select One

- ☐ I Have a Chronic Condition
- ☐ I am a Caregiver

(Please check all that apply)

- ☐ Alzheimer's or Related Dementia
- ☐ Cancer
- ☐ Eye Disease (such as retinopathy)
- ☐ Hypertension (high blood pressure)
- ☐ Osteoporosis (low bone density)
- ☐ Other Chronic Condition _____
- ☐ Arthritis/Rheumatic Disease
- ☐ Depression or Anxiety Disorders
- ☐ Heart Disease
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Breathing/Lung Disease
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Multiple Sclerosis
- ☐ None

How would you rate your overall quality of life? *(Please check one)*

Poor Quality 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ *Excellent Quality*

In general, how would you describe your health? *(Please check one)*

☐ Poor ☐ Fair ☐ Good ☐ Very Good

First Name _____ **Last Name** _____

Date _____

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

1. **How confident are you that you can keep the fatigue caused by your disease from interfering with the things you want to do?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

2. **How confident are you that you can keep the physical discomfort or pain of your disease from interfering with the things you want to do?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

3. **How confident are you that you can keep the emotional distress caused by your disease from interfering with the things you want to do?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

4. **How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

5. **How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10

6. **How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?**

Not At All Confident *Totally Confident*

1 2 3 4 5 6 7 8 9 10