National DPP Participant Personal Information

Name:_____ Gender: M F Date of Birth:_____

Height: _____ Current Weight: _____ Ethnicity: Are you Hispanic or Latino? Yes No

Address:_____ City:_____County:_____

Email:_____ Phone: _____

Race: (Please check you race)

O White
O Native American/Pacific Islander
O Black /African American
O American Indian/Alaska Native
O Asian

What is the highest level of education/school that you have completed?

O Less than grade 12
O College: 1-3 years
O Grade 12 or GED
O College: 4 years or more

Your Healthcare Provider_____ Clinic _____ Did they refer you? Yes No

How did you hear about National DPP? (Please check all that apply):

- A friend, family member, or coworker
- Someone who participated in NDPP
- A doctor's office of any kind, community clinic, or hospital

Who in the office told you about NDPP? Circle only one answer.

Doctor front desk/admin staff Nurse or Physician's assistant Flyer

- Brochure, flyer, poster, not at a doctor's office
- Story or ad on radio, newspaper, or TV
- Website. Please specify_____
- Other. Please specify_____

Please indicate the type of health care coverage you use (check all that apply):

- Medicare
- Medicaid
- Private Insurance/Health Market
- Veteran's Affairs
- Every Woman Matters
- No coverage
- Employee Plan
- Wise Woman Client

Please circle the best answer or fill in the blanks for the following questions:

Which Nebraska county do you prefer to obtain healthcare? _____

Are you limited in any way because of physical, mental, or emotional problems? Yes No

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If yes, type of disability_____

Do you have a health problem that requires you to use special equipment, such as a cane, wheelchair, special telephone, etc.?
Yes No

Refugee Status: Yes No If yes, from what country?_____

Have you ever been told by a doctor or other health professional that you have:

High blood pressure Yes No Are you taking medication now for it? Yes No

During the past 7 days, how many days, including today, did you take your blood pressure medication? _____

High blood cholesterol Yes No Are you taking medication now for it? Yes No

During the past 7 days, how many days, including today, did you take your cholesterol medication? _____

Diabetes Yes No Are you taking medication now for it? Yes No

During the past 7 days, how many days, including today, did you take your diabetes medication? _____

Are able to obtain the medication prescribed for any of your conditions? Yes No

Have you been diagnosed with coronary heart disease or chest pain? Yes No Don't know

Have you been diagnosed with congenital heart defects? Yes No Don't know

Have you been diagnosed with heart failure? Yes No Don't know

Have you been diagnosed with stroke or transient ischemic attack (TIA)? Yes No Don't know

Have you been diagnosed with vascular disease? Yes No Don't know

Have you been diagnosed as having a heart attack? Yes No Don't know

Are you taking aspirin daily to help prevent heart attack or stroke? Yes No Don't know

Women - Have you had a mammogram in the last 2 years? Yes No N/A (mastectomy)

Women - Have you had a pap test in the last 3 years? Yes No N/A (hysterectomy)

Have you been screened for colorectal cancer? Yes No

Men - Have you been screened for prostate cancer? Yes No

Have you been to a dentist in the last 2 years? Yes No

Do you now smoke tobacco in any form? Current smoker Quit more than 1 year ago never smoked

Do you eat fish two times weekly?	Yes ___ No ___ Don't know ___
How many servings of grain products do you eat daily?	0___ 1___ 2___ 3___ 4___ 5___ 6 or more___ don't know___
Of these, how many are whole grains?	0___ 1___ 2___ 3___ 4___ 5___ 6 or more___ don't know___
Do you drink less than 36 ounces of sweetened beverages weekly?	Yes ___ No ___ Don't know___
Are you currently reducing your sodium or salt intake?	Yes ___ No ___ Don't know___
How much moderate physical activity do you get in a week?	30 min. ___ 60 min. ___ 90 min. ___ 150 min.___ more___ don't know___

How much vigorous physical activity do you get in a week?	0___ 30 min. ___ 60 min. ___ 75 min. or more___ don't know___
How much fruit do you eat in an average day? (1 serving = 1 banana, 1 apple, or a cup of berries)	0___ 1___ 2___ 3___ 4___ 5___ 6 or more___ don't know___
How many vegetables do you eat in a typical day? (1 serving = 12 baby carrots or 1 cup of broccoli	0___ 1___ 2___ 3___ 4___ 5___ 6 or more___ don't know__
Thinking about your physical health, which includes physical illness and injury, how many days of the past 30 was your health **not** good?	0___ 1-5___ 6-10___ 11-20___ 21 or more___
Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?	Not at all nearly half nearly every day
Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?	Not at all nearly half nearly every day

Disclosure Statement – The information provided above is for the purpose of monitoring success in the program and connecting participants with the health resources that may be needed. Your lifestyle coach will send it to PPHD, where it will be protected and destroyed following completion of your program. You may be referred to obtain health screenings and provided with information pertinent to your health.

Authorization to Release Information - I hereby authorize the release of the information contained on this registration form to Panhandle Public Health District. I understand that I may be sent health screening recommendations based on the information provided herein. This information, as well as participant and physician identity, will be kept strictly confidential. The recipient of this participant information is prohibited from disclosing the information to any other party and is required to destroy the information after my participation in the program ends.

Your signature_____Date_____

Biometric Information					
Participant Name					**DOB**
Height	Weight	Waist	BP1	BP2	Total Cholesterol (must follow up if over 240)
Eligibility Information (Please check the eligibility source)					
O Fasting Plasma Glucose			O Hemoglobin A1C		
O Oral Glucose Tolerance Test			O Gestational Diabetes		
O Risk Test					

Participants Age 60 and Over (Please circle or check correct answers or fill in the blanks for the following questions)

Eligibility Status 60+

___Disabled, Living in senior Housing
___Volunteering service during mealtime
___Disabled living with 60+ parent
___Spouse 0f 60+
___Caregiver Service
___Employee, not eligible
___Not employee, not eligible
___Not UDSA Meals Program
___Under 60, Title XX

Marital Status

___Single
___Married
___Divorced
___Widow/Widower

Household Composition

___Live alone
___Live with spouse only
___Live with other family/friend
___Live in group setting

Living Arrangement

___Independent Senior Housing
___Other
___Assisted Senior Housing
___Homeowner/Co-owner
___ Nursing Facility/Other
___Rents/ Live with family or friends

Income Status

___ Income above guidelines
___ Income below guidelines

Income Guidelines

Single $12,490
Couple $16,910

Third Party Payer

Do you receive any of the following benefits? (Circle all that apply)
Medicare Medicaid Medicaid Waiver Social Services Block Grant (Title XX)

Activities of Daily Living (ADL) Instrumental Activities of Daily Living (IADL)

Do you have difficulty with any of the following?

ADL (Circle yes or no)

Yes No Bathing
Yes No Dressing
Yes No Eating
Yes No Toileting
Yes No Transferring
Yes No Walking

IADL (Circle yes or no)

Yes No Heavy Housework
Yes No Light Housework
Yes No Medication Management
Yes No Money Management
Yes No Transportation
Yes No Preparing Meals
Yes No Shopping
Yes No Using the telephone

Nutrition Risk Assessment

Yes No Have you made changes in the way you eat because of an illness or medical condition?
Yes No Do you eat fewer than two meals a day?
Yes No Do you eat at least one serving of fruits and vegetables daily?
Yes No Do you eat at least one serving of dairy products (milk, cheese, yogurt, etc) daily?
Yes No Do you drink more than two alcoholic beverages daily?
Yes No Do you have tooth or mouth problems that make it difficult to eat?
Yes No Do you always have enough money to buy the food you need?

Supplemental Nutrition Assessment

Height Weight

Appetite Fair Good Poor
Yes No Do you have adequate kitchen facilities?
Yes No Do you take dietary supplements?
Yes No Do you have recurring difficulty with constipation or diarrhea?
Yes No Do you drink 6-8 cups of non-alcoholic beverages each day?

Yes No Do you eat alone most of the time?

Yes No Do you take three or more different prescriptions, over-the-counter medications or Vitamins/nutritional supplements daily?

Yes No Have you gained or lost 1O pounds in the last 6 months without wanting to?

Yes No Are you always physically able to shop, cook and feed yourself?

Are you on a special diet? Yes No

If yes, circle the correct diet in the following list:

Bland Diabetic 1200-2400 Finger food Kosher Renal

High calcium Low cholesterol Low lactose Low fat Vegetarian

Low sodium No salt Food texture modification Other