

# IOWA LIVING WELL

## Personal Health Survey

Developed by  
The Center for Disabilities and Development and  
The College of Public Health  
University of Iowa

In collaboration with  
The Iowa Department of Public Health and  
The Prevention of Disabilities Policy Council

With funding from  
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Adapted from the evaluation designed by the CDC  
*Consortium to Evaluate the Efficacy of Health Promotion  
Interventions for People with Disabilities*

Name: \_\_\_\_\_

ID: \_\_\_\_\_

**Section One: Health Care You've Received**

For the following questions about health care you've received, please circle "0" if the answer is none. (If the answer is more than thirty, check the box "Over 30" on the right.)

1. In the last two months, how many times did you visit a primary health care provider (e.g., your regular doctor's office or other regular health care provider)? (Please circle the number of visits)

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →  Over 30

1a. How many of these visits were for regular or routine annual checkups?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →  Over 30

1b. How many of these visits were for specific problems you were having?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →  Over 30

2. In the last two months, how many times did you visit a specialist (e.g., cardiologist, oncologist, psychiatrist, etc)?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →  Over 30

3. In the last two months, how many nights were you hospitalized?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →  Over 30

3a. If you were hospitalized during the last two months, how many nights (if any) did you spend in an intensive care unit?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →  Over 30

4. In the last two months, how many visits did you make to an emergency room?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →  Over 30

5. In the last two months, how many times did you have out-patient surgery (surgery for which you did not stay overnight at the hospital)?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →  Over 30

6. In the past six months, have you seen a dietician/nutrition specialist? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
7. In the past six months, have you received home health nursing care? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
8. In the past six months, did you receive all the medical or health care services you needed or wanted? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**Section Two: Your General Health**

9. Looking back over the last two months, how would you rate your general health? 

Poor	Fair	Good	Very Good	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any health problems that require you to use special equipment such as a cane, wheelchair, special bed, special telephone, etc.? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
11. During the past 30 days, for about how many days did pain make it hard for you to do your usual activities, such as self-care, work, or recreation? *(Please circle the number of days)*
- ← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →
12. During the past 30 days, for about how many days have you felt that you did not get enough rest or sleep?
- ← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →
13. During the past 30 days, for about how many days have you felt very healthy and full of energy?
- ← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →
14. Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?
- ← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →
15. Because of any impairment or health problem, do you need the help of other people with:
- A. taking care of your routine needs, such as everyday household, chores, doing necessary business, shopping or getting around for other purposes? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
- B. taking care of your personal care needs such as eating, bathing, dressing or getting around the house? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**16.** How TRUE or FALSE is each of the following statements for you? (Circle **one** on each line)

	<b>Definitely True</b>	<b>Mostly True</b>	<b>Don't Know</b>	<b>Mostly False</b>	<b>Definitely False</b>
a. I seem to get sick a bit easier than other people	1	2	3	4	5
b. I'm as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5

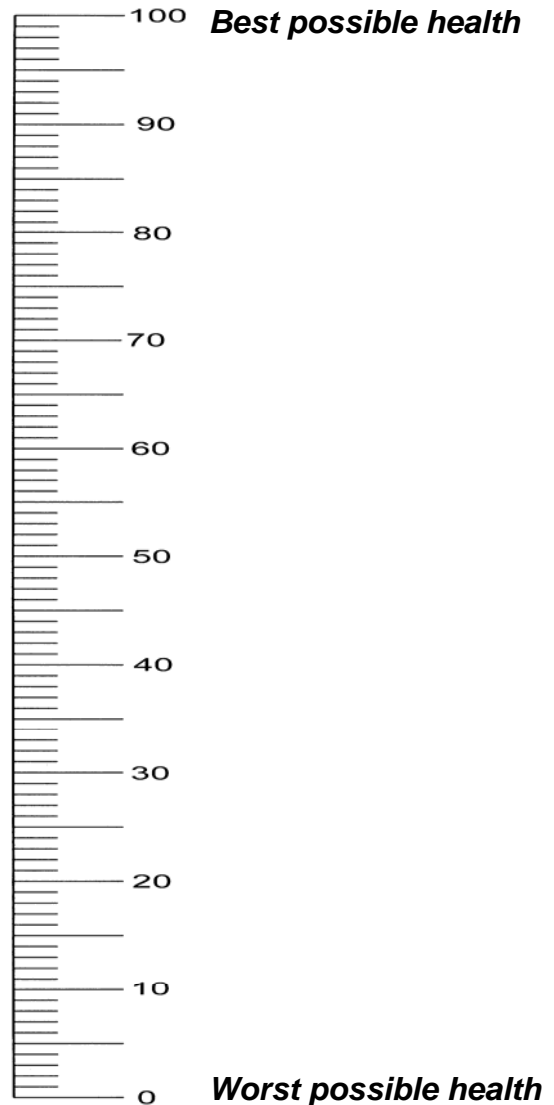
**17. How healthy are you?**

This scale is like a thermometer that measures how good or bad your health is. The best possible health you can imagine is at 100. The worst possible health you could imagine is at 0.

Please put a mark on the scale next to the number that shows how good or bad your health is right now.

Please write the number you marked here:

\_\_\_\_\_



**SECTION THREE: YOUR SOCIAL HEALTH**

18. In the last two months, how satisfied would you say you are with your life in general?

<b>Very Satisfied</b>	<b>Somewhat Satisfied</b>	<b>Somewhat Dissatisfied</b>	<b>Very Dissatisfied</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. In the last two months, how often would you say that you got the social and emotional support you need?

<b>Never</b>	<b>Rarely</b>	<b>Sometimes</b>	<b>Usually</b>	<b>Always</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. During the past 30 days, for about how many days have you felt sad, blue, or depressed?  
(Please circle the number of days)

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →

21. During the past 30 days, for about how many days have you felt little interest or pleasure in doing things?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →

22. During the past 30 days, for about how many days have you felt worried, tense, or anxious?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →

23. Thinking about your mental health (which includes stress, depression and problems with emotions), for how many days during the past 30 days was your mental health not good?

← 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 →

24. How much of the time during the past 30 days. . . .

	<b>All of the Time</b>	<b>Most of the Time</b>	<b>Some of the Time</b>	<b>A Little Bit of the Time</b>	<b>None of the Time</b>
a. have you been a happy person?	1	2	3	4	5
b. did you feel tired?	1	2	3	4	5
c. has your health or disability interfered with your social life?	1	2	3	4	5

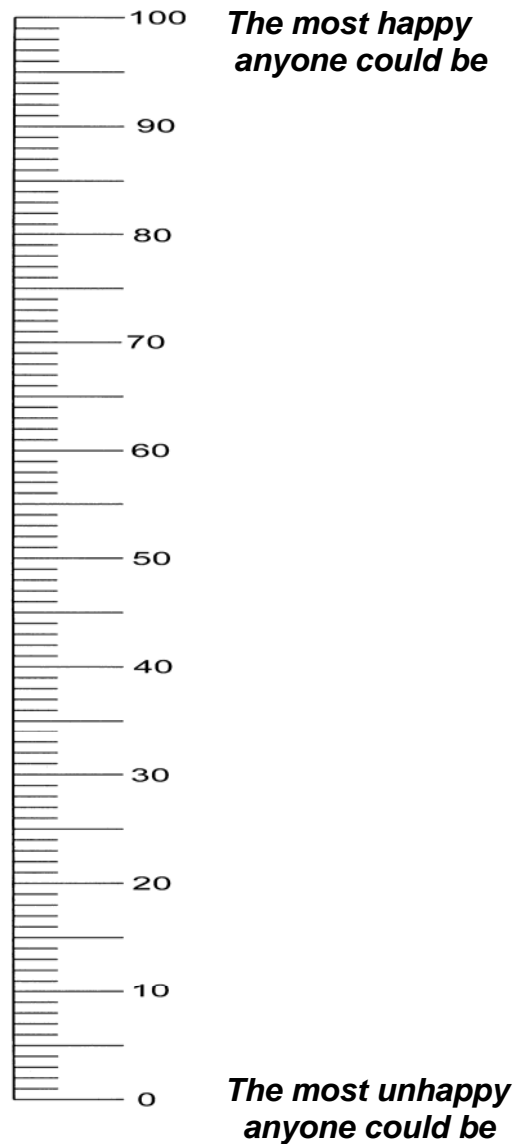
## 25. How happy are you?

This scale is like a thermometer that measures how happy you feel. The most happy anyone can be is at 100. The most unhappy anyone can be is at 0.

Please put a mark on the scale next to the number that shows how happy you are right now.

Please write the number you marked here:

— — —





- Limit snacks and “junk” food
- Meditate or relax to reduce stress
- Talk about problems instead of keeping them to yourself
- Use positive thoughts to cope with problems or stress
- Do something to improve my mood when I feel blue
- Stay away from drugs, alcohol, and smoking
- Wear seat belts
- Wear a helmet when riding a bike or motorcycle
- Keep active with friends

**31. [WOMEN ONLY:]** In the past three years, had you had a PAP SMEAR? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**32. [WOMEN OVER AGE 40:]** In the past two years, have you had a routine MAMMOGRAM? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**33. [MEN OVER AGE 40:]** In the past two years, have you had a routine PROSTATE exam or PSA blood test? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**34.** In the past six months, have you used a home or herbal remedy instead of a prescription medicine because you thought the remedy was better? 

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

**35.** *(circle one number on each line)*

How much is each statement like you?		A lot like me	Somewhat like me	Only a little like me	Not at all like me
a.	I ask the doctor to explain things when I don't understand.	1	2	3	4
b.	I tell the doctor when I disagree with him/her.	1	2	3	4
c.	I prepare a list of questions for my doctor before every appointment.	1	2	3	4
d.	I am very satisfied with how well my doctor and I communicate.	1	2	3	4

**36.** *(circle one number on each line)*

How good are you at doing the following things?	Very Good	Good	OK	Poor	Very Poor
a. Letting people know how you feel or what you want	1	2	3	4	5
b. solving a problem on your own	1	2	3	4	5
c. setting goals for yourself	1	2	3	4	5

**37.** About how many families in your neighborhood are you well enough acquainted with, that you visit each other in your homes? Number of Families = \_\_\_\_\_ *(Write in number; if none, enter "0")*

38. About how many close friends (including relatives) do you have – people you feel at ease with and can talk with about what is on your mind? Friends = \_\_\_\_\_ (Write in number; if none, enter “0”)

39. In the past two months have you attended a support group of any kind? (Circle one)

Yes, Usually	Yes, Sometimes	No, Never
1	2	3

**SECTION FIVE: HAVE THESE CONDITIONS AFFECTED YOUR ACTIVITY AND INDEPENDENCE?**

40. Please tell us how much each of the following secondary conditions has affected your activity and independence in the last two months. A secondary condition is a problem experienced after you have a primary disability. Like a primary disability, a secondary condition may restrict your ability to do things independently. Please use the following scale in making your decisions.

**None**      ➤ *I have not experienced this during the past two months or it rarely limits my activity or independence.*

**Mild**      ➤ *This is a mild or infrequent problem for me; it limits my activity 1 to 5 hours per week.*

**Moderate** ➤ *This is a moderate/occasional problem; it limits my activity 6 to 10 hours per week.*

**Significant** ➤ *This is a significant/chronic problem; it limits my activity 11 or more hours per week.*

Condition	Description	How Much Does This Condition Limit Your Activity and Independence?			
		None or Rarely	Mild or Infrequent (1-5 hours/week)	Moderate/ Occasional (6-10 hours/week)	Significant/ Chronic (11 or more hours/week)
<b>Pressure Sores</b>	These sores start as redness or a rash and develop into large infected sores. Also called skin ulcers, bedsores, or decubitus ulcers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Injuries Due to Loss of Sensation</b>	Some people have disabilities that cause a loss of sensation, such as a spinal cord injury or MS. They can have injuries because they cannot feel pain in some areas (e.g., frostbite or burns from sitting too close to a fire).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Care-related Injuries to You</b>	When others provide your care, injuries can occur (e.g., bumps or broken bones during transfers)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Amputation</b>	Having a limb(s) removed for medical reasons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		None or Rarely	Mild or Infrequent (1-5 hours/week)	Moderate/ Occasional (6-10 hours/week)	Significant/ Chronic (11 or more hours/week)
<b>Spasticity (Muscle Spasms)</b>	Uncontrolled, jerky muscle movements such as twitches or spasms. Persons with MS, CP, and Spinal Cord Injury are at risk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Curvature of the Spine</b>	Scoliosis, kyphosis or lordosis. People with Spinal Cord Injuries are at risk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Contractures</b>	A contracture is a problem in extending an arm or leg because the muscles at a joint (like an elbow or knee) are too tight to move freely and fully. Trying to straighten out these joints usually causes a lot of pain.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Arthritis</b>	Caused by inflammation of the joints, making movement both difficult and painful. Symptoms include pain and swelling around the joints.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Osteoporosis</b>	A wasting of bone. It may cause pain and can lead to fractures. Anyone who does not have adequate weight bearing exercise may develop this. Women are especially at risk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Fatigue</b>	Fatigue is a tired (though not necessarily sleepy) feeling after even a little activity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eating or Weight Problems</b>	Includes difficulty in regulating weight and problems with eating (e.g., overeating, under eating, vomiting food).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Physical Fitness or Conditioning Problems</b>	Not able to do as much as you would like because you are out of shape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		None or Rarely	Mild or Infrequent (1-5 hours/week)	Moderate/ Occasional (6-10 hours/week)	Significant/ Chronic (11 or more hours/week)
<b>Bladder Dysfunction</b>	Symptoms may include incontinence, bladder or kidney stones, kidney problems, leakage, or urine back-up.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Urinary Tract Infections</b>	Symptoms include pain on urination, a burning sensation throughout the body, blood in the urine, and cloudy urine.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bowel Dysfunction</b>	Diarrhea, constipation, or "accidents" are signs of bowel dysfunction.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sexual Dysfunction</b>	Includes dissatisfaction with sexual functioning. Causes can be decreased sensation, changes in body image, difficulty in movement, and concern over bladder and bowel routines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Carpel Tunnel Syndrome</b>	A nerve disorder in the hand. It results from frequent repetitive motion such as wheeling a chair. Symptoms include numbness or tingling in the hand, shooting pain up the arm, thumb weakness, or dropping things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Postural Hypotension</b>	Lightheadedness following a change of position. Caused by a sudden drop in blood pressure. Those with stroke or Spinal Cord Injury are at risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cardiovascular (Heart) Disease</b>	Commonly involves high or low blood pressure. May be signaled by fluid retention, particularly around the ankles. Needs doctor diagnosis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anger</b>	Extreme displeasure with situations or persons that is difficult to control.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		None, Rarely, Never	Mild or Infrequent (1-5 hours/week)	Moderate/ Occasional (6-10 hours/week)	Significant/ Chronic (11 or more hours/week)
<b>Access Problems</b>	Obstacles at work or in the community that make it difficult for you to be independent (e.g., no curb cuts or inaccessible buildings, exam rooms, or restrooms).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Circulatory Problems</b>	Swelling of veins or feet, or the occurrence of blood clots.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Chronic Joint &amp; Muscle Pain</b>	This includes pain in muscle groups or joints. Those who have to use the same muscles a lot (e.g., persons in a wheelchair or who use crutches may strain shoulder muscles) or those who must put too much strain on their joints are at risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory Problems</b>	Pneumonia and other respiratory infections can occur in people with disabilities. Persons with quadriplegia, post polio, rheumatoid arthritis and MS are especially at risk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Depression</b>	More than just feeling blue. Symptoms include: extreme, long-term sadness; loss of pleasure in favorite activities; difficulty sleeping; weight loss or gain; frequent unexplained crying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Isolation</b>	Not having enough social contact or support from others. May be caused by a loss of relationships or being house-bound.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Problems with Mobility</b>	Difficulty getting around due to a loss of strength or muscle control.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

		None, Rarely, Never	Mild or Infrequent (1-5 hours/week)	Moderate/ Occasional (6-10 hours/week)	Significant/ Chronic (11 or more hours/week)
<b>Equipment Failures</b>	Equipment failures, such as a broken walker or brace, can limit what you can do on your own, make things harder to do, or stop you from doing everything you want to do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Equipment-related Injuries to Yourself</b>	Using special equipment can lead to injuries (e.g., abrasions from wheelchairs or ill-fitting crutches) that can further limit what you can do.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Side Effects from Medications</b>	For people with disabilities or health problems the use of multiple medications can produce side effects that further limit what you can do independently.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Alcohol/Drug Abuse</b>	Over reliance on alcohol or drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Anemia</b>	A low level of iron in the blood that often occurs when there are pressure sores, ulcers, or other bleeding problems. Anemia leads to fatigue and low energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sleep Problems/ Disturbances</b>	Difficulty falling asleep or staying asleep, difficulty staying awake during the day, or waking up too early are all sleep disturbances.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Diabetes</b>	A result of irregularities in blood sugar levels. Symptoms include frequent urination and excessive thirst. Needs doctor diagnosis.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Verbal Communication Difficulties</b>	Difficulty in talking due to stroke, use of a ventilator, and/or speech impairments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Visual Problems</b>	Significant loss of your ability to see, including blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hearing Problems</b>	Difficulty with hearing in general or with hearing particular kinds of sounds.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Injuries to Caretakers</b>	Injury to your caretaker from lifting, transferring, handling specialized equipment, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Written Communication Problems</b>	May be due to low vision, reading disorders, or physical limitations that prevent writing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**41. Now we have questions about health conditions that a doctor may have told you about.**

Has a doctor <b>ever</b> told you that...	YES	NO	DON'T KNOW
a. you had curvature of the spine (scoliosis, kyphosis, or lordosis)?	1	2	3
b. you had arthritis, osteoarthritis, or rheumatoid arthritis?	1	2	3
c. you had osteoporosis?	1	2	3
d. you had carpal tunnel syndrome?	1	2	3
e. you had high blood pressure?	1	2	3
f. you had a heart attack, coronary, coronary thrombosis, coronary occlusion, or myocardial infarction?	1	2	3
g. you had a stroke or brain hemorrhage?	1	2	3
h. you had epilepsy, seizures, spells, or fits?	1	2	3
i. you had any cancer, malignancy, or tumor of any type?	1	2	3
j. you had diabetes, high blood sugar, or sugar in your urine?	1	2	3
k. you had a broken or fractured hip?	1	2	3
l. you had broken or fractured any other bones?	1	2	3
m. you had anemia, low blood, or trouble with your blood?	1	2	3
n. you had depression?	1	2	3
o. you had a urinary track or bladder infection?	1	2	3
p. you had pneumonia?	1	2	3
q. that you needed any limbs, including fingers and toes, amputated?	1	2	3

**Section Six: Background Information**

42. What is your gender?  Female  Male

43. What is your age?

44. What is your current height (without shoes)? \_\_\_ feet \_\_\_ inches

45. What is your current weight (without shoes)? \_\_\_ pounds

46. What is the highest educational degree you have obtained?

- Some high school or less
- High School degree or GED
- Associate (AA) degree
- Bachelors degree
- Masters degree
- Doctoral degree

47. Which one of these groups would you say best represents your race?

- White
- Black or African American
- Hispanic or Latino
- Asian
- American Indian or Alaska Native
- Native Hawaiian or Pacific Islander
- Other: \_\_\_\_\_

48. What is your marital status?

- Married
- Divorced/Separated
- Widowed
- Never Married

49. Which ONE of the following best describes your work status:

- Working full-time in a job for which I get paid..... 1
- Working part-time in a job for which I get paid..... 2
- Working with help from a coach in a job for which I get paid..... 3
- Working in a sheltered workshop..... 4
- Working in a volunteer position..... 5
- Working as a full-time homemaker..... 6
- In school or a training program..... 7
- Retired..... 8
- Not working and not in school or a training program..... 9

50. What is your approximate annual income from all sources?

- Less than \$10,000
- \$10,000-\$14,999
- \$15,000-\$19,999
- \$20,000-\$24,999
- \$25,000-\$34,999
- \$35,000-\$49,999
- \$50,000-\$74,999
- \$75,000 or more

51. Do you currently have health care coverage/insurance from any source -- public or private?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

51a. What type(s) of insurance do you have? (Check all that apply)

- Medicaid
- Medicare
- Private Insurance

52. What is your primary health condition or disability? \_\_\_\_\_

53. What other problems or conditions do you have? (Check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Brain Injury           | <input type="checkbox"/> Legal Blindness   | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Spinal Cord Injury     | <input type="checkbox"/> Memory Deficits   | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> Learning Problems | <input type="checkbox"/> Heart Condition    |
| <input type="checkbox"/> Attention Problems     | <input type="checkbox"/> Autism/Asperger's | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> Problems from a Stroke | <input type="checkbox"/> Speech Problems   | _____                                       |
| <input type="checkbox"/> Parkinson's Disease    | <input type="checkbox"/> Mobility Problems |   |
| <input type="checkbox"/> Spina Bifida           | <input type="checkbox"/> Diabetes          |   |
| <input type="checkbox"/> Amputated Limbs        | <input type="checkbox"/> Seizures          |   |
| <input type="checkbox"/> Hearing Problems       | <input type="checkbox"/> Depression        |   |
| <input type="checkbox"/> Post Polio Syndrome    | <input type="checkbox"/> Cerebral Palsy    |   |

54. Date you completed this form: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(Month) (Day) (Year)

***Thank you for taking time to complete this survey!***