

# Arthritis Exercise & Education Course Participant Evaluation Form

*Please help us improve future offerings by evaluating this program and the facility.*

Course Leader Name(s): \_\_\_\_\_

Course Dates: \_\_\_\_\_ through \_\_\_\_\_

Course Location: \_\_\_\_\_

Please check the appropriate box.

- Arthritis Foundation Exercise Program       Arthritis Foundation Self-Help Course  
 Chronic Disease Self Management Program       Arthritis Foundation Aquatics Program

*Circle a response for each item as appropriate. If you rate an item poor or very poor, please briefly explain why in the comments section below.*

Facility Characteristics	Very Good	Good	Average	Poor	Very Poor
Convenience of location	5	4	3	2	1
Building Accessibility	5	4	3	2	1
Ease and safety of pool entry and exit	5	4	3	2	1
Water temperature	5	4	3	2	1

Comments: \_\_\_\_\_

*Please circle a response for each statement. If you rate a statement as Not at All True, please briefly explain why in the comments section below.*

Participation in this course has	Very True	Somewhat True	Not at All True	Unsure	Not Applicable
Made me more confident in my ability to take care of my chronic condition.	5	4	3	2	1
Increased my range of motion and relieved joint stiffness.	5	4	3	2	1
Increased my independence and ability to carryout daily activities.	5	4	3	2	1
Decreased my chronic condition-related pain or symptoms.	5	4	3	2	1
Improved my mood and self-esteem.	5	4	3	2	1

Comments: \_\_\_\_\_

1) This course met my expectations? *(Please check the appropriate response.)*  
 Yes       No       Unsure      If no or unsure, why not? \_\_\_\_\_

2) I found the following aspect(s) of the course the most helpful: \_\_\_\_\_

3) I would make the following change(s) to this course: \_\_\_\_\_

4) I learned about this course from: *(Please check all that apply.)*

- |   |   |
|---|---|
| <input type="checkbox"/> Regional Arthritis Center        | <input type="checkbox"/> Arthritis Foundation               |
| <input type="checkbox"/> Information received in the mail | <input type="checkbox"/> Family Member or Friend            |
| <input type="checkbox"/> Physician Referral Dr. _____     | <input type="checkbox"/> Community Presentation/Health Fair |
| <input type="checkbox"/> Other (Please specify.) _____    |   |

5) I participated in this course to: *(Please check all that apply.)*

- Alleviate the physical symptoms caused by my chronic condition.
- Learn more about chronic disease and self-management techniques.
- Interact with other people with chronic conditions who have similar problems as myself.
- Other (Please specify.) \_\_\_\_\_

6) I have been participating in an exercise or self-management program for:

- a) First Time            b) Several Times: \_\_\_ Years, \_\_\_ Months  
c) Unsure \_\_\_

7) I will make changes in my chronic condition care as a result of participation in this course?

- Yes             No             Unsure

If yes, I will make the following changes: *(Please check all that apply.)*

- |  |  |
|--|--|
| <input type="checkbox"/> practice relaxation techniques  | <input type="checkbox"/> change to healthier eating habits   |
| <input type="checkbox"/> do more stretching exercises    | <input type="checkbox"/> join a support group                |
| <input type="checkbox"/> do more strengthening exercises | <input type="checkbox"/> improve relationship with/my doctor |
| <input type="checkbox"/> other (please specify): _____   |  |

8) Would you recommend this course to other people with chronic conditions? *(Please check one.)*

- Yes             No             Unsure    If no or unsure, why not? \_\_\_\_\_

**OPTIONAL:**

9) What is your race/ethnicity? *(Please check all that apply.)*

- |  |   |
|--|---|
| <input type="checkbox"/> White, non-Hispanic | <input type="checkbox"/> Asian or Pacific Islander, non-Hispanic      |
| <input type="checkbox"/> Black, non-Hispanic | <input type="checkbox"/> American Indian/Alaskan Native, non-Hispanic |
| <input type="checkbox"/> Hispanic            | <input type="checkbox"/> Other (please specify): _____                |

10) What is your age? *(Please check the appropriate category.)*

- |                                      |                                      |                                      |
|--------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Unknown     | <input type="checkbox"/> 25-34 years | <input type="checkbox"/> 55-64 years |
| <input type="checkbox"/> < 18 years  | <input type="checkbox"/> 35-44 years | <input type="checkbox"/> 65-74 years |
| <input type="checkbox"/> 18-24 years | <input type="checkbox"/> 45-54 years | <input type="checkbox"/> 75+ years   |

*Thank you for participating in the program and completing the evaluation form!*

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