# East Valley Community Health Center

## COMMUNITY SURVEY

**1. What is your age?** ____________________

**2. In what zip code do you live?** ____________________

**3. Which one of the following best describes you? (Choose one)**

[ ] Single
[ ] Married
[ ] Widowed
[ ] Divorced
[ ] Living with partner
[ ] Other _____________

**4. What is your gender?**

[ ] Female
[ ] Male

**5. Do you consider yourself the head of the household?**.................. [ ] yes [ ] no

**6. How many children less than 18 years of age for which you are responsible?** ________ *If "0"* →

**If you are not responsible for any children (0 children) under 18, skip to question 7.**

**6a. If you do have children less than 18 years of age for which you are responsible, what are the ages of the children?**

_____ _____ _____ _____ _____ _____ _____
age age age age age age age

**7. Which racial/ethnic group do you most closely identify? (Choose one)**

[ ] Black
[ ] American Indian
[ ] Asian-American
[ ] White
[ ] Latino
[ ] Multi-racial → Please list your racial/ethnic make-up: ____________________________________________
[ ] Other ↘ Please specify: ______________________

***Responses will be held in the strictest confidence.***

**Please turn over the page to continue the survey.**

**8. What is your highest education level completed? And, if you are not head of the household, what is the highest educational level completed by the head of household?**

[ ] I am head of household

| YOU | HEAD OF HOUSEHOLD |
|---|---|
| [ ] Middle school or less | [ ] Middle school or less |
| [ ] Some high school | [ ] Some high school |
| [ ] High school graduate/G.E.D. | [ ] High school graduate/G.E.D. |
| [ ] Trade school | [ ] Trade school |
| [ ] Some college | [ ] Some college |
| [ ] College graduate | [ ] College graduate |
| [ ] Post-graduate degree | [ ] Post-graduate degree |

**9. Which of the following best describes your current living situation? (Choose one)**

[ ] Own your home
[ ] Rent your home/apartment
[ ] Rent a room in someone else's home/apartment
[ ] Live in subsidized housing (i.e., Section 8)
[ ] Live in a shelter
[ ] Homeless/no identifiable residence
[ ] Other
Please specify: ______________________________

**10. Which of the following best describes your current household make-up? (Choose one)**

[ ] I live alone
[ ] I live with my family only (e.g., husband, child(ren) under 18 years of age for which you are responsible)
[ ] I live with my family and one or more other relatives (e.g., parent(s), brother(s), aunt(s), and grandparent(s))
[ ] I live with my family and another family not related to me
[ ] I live with my family and two or more families not related to me
[ ] Other
Please specify: ______________________________

**11. Are you employed?** .................. [ ] yes [ ] no

**If "no", skip to question 12, which is at the top of page 3.**

**11a. If yes, how many hours a week do you typically work?**

[ ] 10 hours or less
[ ] 11 to 20 hours
[ ] 21 to 30 hours
[ ] 31 to 40 hours
[ ] 41 hours or more

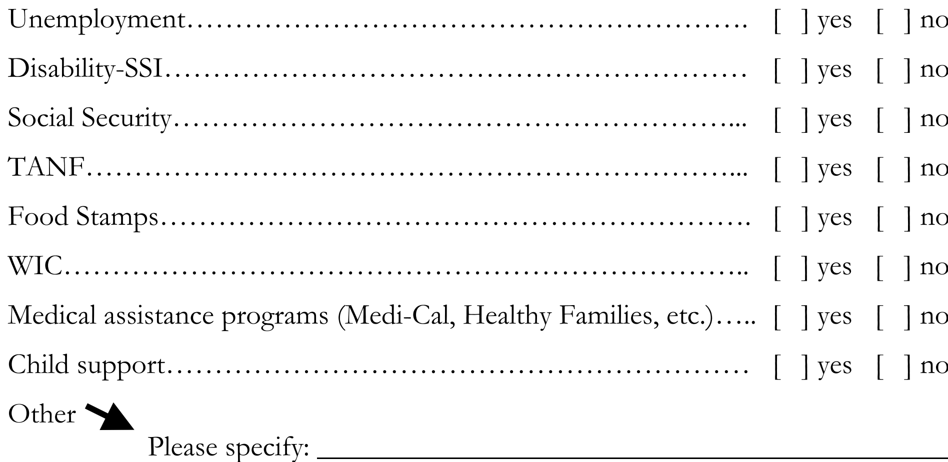
**12. Is the <u>head of the household</u> employed?** .................. [ ] yes [ ] no [ ] I am the head of household

**If "no" or "I am the head of household," skip to question 13.**

**12a. If yes, how many hours does the <u>head of the household</u> typically work?**

[ ] 10 hours or less
[ ] 11 to 20 hours
[ ] 21 to 30 hours
[ ] 31 to 40 hours
[ ] 41 hours or more

**13. Which, if any of these assistance programs, help to support you and any family members living with you?**



Unemployment…………………………………………………. [ ] yes [ ] no
Disability-SSI………………………………………………… [ ] yes [ ] no
Social Security……………………………………………….... [ ] yes [ ] no
TANF………………………………………………………….... [ ] yes [ ] no
Food Stamps…………………………………………………. [ ] yes [ ] no
WIC…………………………………………………………….. [ ] yes [ ] no
Medical assistance programs (Medi-Cal, Healthy Families, etc.)….. [ ] yes [ ] no
Child support………………………………………………… [ ] yes [ ] no
Other
Please specify: ______________________________

**14. Do <u>you</u> have any medical insurance? (e.g., from an employer or self-pay)** …......[ ] yes [ ] no

**If "no", skip to question 15.**

**14a. Does this insurance company or program cover any other members of your family living with you?** ........................................... [ ] yes [ ] no

**15. Does <u>anyone else in your family</u> have any medical insurance? (e.g., from an employer or self-pay)**……………........................................[ ] yes [ ] no

**If "no", skip to question 16, which is on the top of page 4.**

**15a. Does this insurance company or program cover any other members of your family living with you besides the family member?** ..........................................................................................[ ] yes [ ] no

**Please turn over the page to continue the survey.**

**16. What is the combined total yearly income for you and family members that live with you? (Choose one)**

[ ] $5,000 or less
[ ] $5,001 - $10,000
[ ] $10,001 - $15,000
[ ] $15,001 - $20,000
[ ] $20,001 - $25,000
[ ] $25,001 - $30,000
[ ] $30,001 - $35,000
[ ] $35,001 - $40,000
[ ] $40,001 - $45,000
[ ] $45,001 - $50,000
[ ] More than $50,000

**17. How do you and those with whom you live usually get to places? (You may choose "yes" for more than one category)**

Public transportation (e.g., bus, taxi, or shuttle)………... [ ] yes [ ] no
Automobile owned by you or family member………….. [ ] yes [ ] no
Automobile owned by a friend ………………………… [ ] yes [ ] no
Bicycle…………………………………………………. [ ] yes [ ] no
Walk............................................................................................ [ ] yes [ ] no

Other

Please specify: ______________________________________________

**18. What is the approximate travel time (in minutes) to the health center/clinic where you and others members of your household travel to receive routine healthcare?**

_________ minutes [ ] I/we don't receive routine healthcare

**19. What is the approximate travel time (in minutes) to the place where you and other members of your household travel to pick-up prescription drugs?**

_________ minutes [ ] I/we don't use prescription drugs

**20. How many times in the last 12 months have <u>you</u> used a hospital emergency room?**

_________ times

**21. How many times in the last 12 months has a <u>family member(s)</u> living with you used a hospital emergency room ?**

__________ times [ ] N/A, I live alone

**22. Do you or other family members living with you sometimes have a need for any of the following services?**

| | YOU | | FAMILY MEMBERS | | |
|---|---|---|---|---|---|
| | Yes | No | Yes | No | I Live Alone |
| A. General health care services………………………………… | [ ] | [ ] | [ ] | [ ] | [ ] |
| B. Prenatal services (pregnancy)…………………………….. | [ ] | [ ] | [ ] | [ ] | [ ] |
| C. Pediatric services (children's services)……………………. | [ ] | [ ] | [ ] | [ ] | [ ] |
| D. Women's health care (e.g., pap smears)…………………... | [ ] | [ ] | [ ] | [ ] | [ ] |
| E. Diabetes Care…………………………………………….. | [ ] | [ ] | [ ] | [ ] | [ ] |
| F. Asthma Care………………………………………………… | [ ] | [ ] | [ ] | [ ] | [ ] |
| G. High Blood Pressure Care………………………………… | [ ] | [ ] | [ ] | [ ] | [ ] |
| H. Counseling Services / Mental Health Care………………... | [ ] | [ ] | [ ] | [ ] | [ ] |
| I. Help Getting Services (case management)………………… | [ ] | [ ] | [ ] | [ ] | [ ] |
| J. Parenting education………………………………………. | [ ] | [ ] | [ ] | [ ] | [ ] |
| K. Family planning services (birth control)…………………… | [ ] | [ ] | [ ] | [ ] | [ ] |
| L. Vision care………………………………………………… | [ ] | [ ] | [ ] | [ ] | [ ] |
| M. Foot care………………………………………………….... | [ ] | [ ] | [ ] | [ ] | [ ] |
| N. Dental care………………………………………………… | [ ] | [ ] | [ ] | [ ] | [ ] |
| O. Alcohol/drug abuse prevention and treatment…………….. | [ ] | [ ] | [ ] | [ ] | [ ] |
| P. Weight management………………………………………. | [ ] | [ ] | [ ] | [ ] | [ ] |
| Q. AIDS services……………………………………………... | [ ] | [ ] | [ ] | [ ] | [ ] |
| R. Immigration and other legal services………………………. | [ ] | [ ] | [ ] | [ ] | [ ] |
| S. Quitting smoking………………………………………….. | [ ] | [ ] | [ ] | [ ] | [ ] |

**Please turn over the page to continue the survey.**

**23. Please let us know if have any of the following health problems, and if you do, whether a doctor or other health professional diagnosed it, and whether you take medication for it. If you answer "yes" to having the *health problem*, please respond as in the example below to the questions, *"Is the health problem doctor or health professional diagnosed?"* and *"Do you take medication for the health problem?"* If you answer "no", simply move on the next question.**

**Example: Answering "yes" to a health problem**

| | **Health Problem** | **Is the health problem doctor or health professional diagnosed?** | **Do you take medication for the health problem?** |
|---|---|---|---|
| Do you have a hearing problem? | [ x ] yes [ ] no | [ x ] yes [ ] no | [ ] yes [ x ] no |

| | **Health Problem** | **Is the health problem doctor diagnosed?** | **Do you take medication for the health problem?** |
|---|---|---|---|
| A. Do you have a hearing problem? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| B. Do you have high blood pressure? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| C. Do you have arthritis? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| D. Do you have dental problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| E. Do you have heart problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| F. Do you have lung problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| G. Do you have blood circulation problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| H. Have you had a stroke? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| I. Do you have kidney problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| J. Do you have stomach/intestinal problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| K. Have you ever been diagnosed with cancer? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| L. Are you HIV positive or have AIDS? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| M. Do you have seizures? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| N. Do you have diabetes? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| O. Do you feel depressed? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| P. Do you have eye or vision problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| Q. Do you have thyroid problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| **Question for women only** | | | |
| R. Do you have GYN problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |
| **Question for men only** | | | |
| S. Do you have prostate problems? | [ ] yes [ ] no | [ ] yes [ ] no | [ ] yes [ ] no |

**24. Does any child less than 18 years of age for which you are responsible have any of the following health problems?**

[ ] I do not have any child(ren) less than 18 years of age.

| | Yes | No |
|---|---|---|
| A. Does your child(ren) have a hearing problem?................................................................................ | [ ] | [ ] |
| B. Does your child(ren) have high blood pressure?............................................................................ | [ ] | [ ] |
| C. Does your child(ren) have arthritis?.............................................................................................. | [ ] | [ ] |
| D. Does your child(ren) have dental problems?.................................................................................. | [ ] | [ ] |
| E. Does your child(ren) have heart problems?..................................................................................... | [ ] | [ ] |
| F. Does your child(ren) have asthma or bronchitis?............................................................................ | [ ] | [ ] |
| G. Does your child(ren) have blood circulation problems?.................................................................. | [ ] | [ ] |
| H. Has your child(ren) had a stroke?.................................................................................................. | [ ] | [ ] |
| I. Does your child(ren) have kidney problems?.................................................................................. | [ ] | [ ] |
| J. Does your child(ren) have stomach/intestinal problems?................................................................ | [ ] | [ ] |
| K. Has your child(ren) ever been diagnosed with cancer?................................................................... | [ ] | [ ] |
| L. Is your child(ren) HIV positive or have AIDS?............................................................................... | [ ] | [ ] |
| M. Does your child(ren) have seizures?.............................................................................................. | [ ] | [ ] |
| N. Does your child(ren) have diabetes?............................................................................................... | [ ] | [ ] |
| O. Does your child(ren) feel depressed?.................................................................................... | [ ] | [ ] |
| P. Does your child(ren) have eye or vision problems?........................................................................ | [ ] | [ ] |
| Q. Does your child(ren) have thyroid problems?.................................................................................. | [ ] | [ ] |
| R. Does your child(ren) have symptoms of hyperactivity or Attention Deficit Disorder?................ | [ ] | [ ] |

**25. Do you or anyone else in your family use herbs or other natural remedies for a health-related problem(s)? (e.g., manzanilla, ruda, siete asares, or yerba buena)**.............................................................................. [ ] yes [ ] no

**Please turn over the page to continue the survey**

**26. Is there anything else you would like to share with us?** ____________________________________________

# THANK YOU!