

# ALLEN TEMPLE HEALTH EDUCATION HEALTHY TEMPLE SURVEY

The mission of the Allen Temple's Health Education Committee is to embody God's love and move our congregation and community toward wholeness of body, mind and spirit. Currently members are provided with health education messages and screenings that encourage health and wholeness at our annual health fair and in our church bulletin. The Health Education Committee also intends to provide a health screenings and assessments in the Robert Scott Wellness Center on a monthly or weekly basis.

The purpose of this survey is to assess the health and physical needs of the congregation and East Oakland community. By your responses, you will provide direction for the Health Education Committee in two ways. First, your responses will provide a general overview of the needs of the congregation. Second, your responses will help provide direction for specific health education programs and screenings needs within the congregation. PLEASE DO NOT WRITE YOUR NAME ON THIS SURVEY. IT SHOULD BE COMPLETELY ANONYMOUS. PARENTS OF CHILDREN AGE 17 OR LESS, PLEASE COMPLETE THE SURVEY FOR YOUR CHILD.

Please answer all questions openly and honestly. If you need to speak with someone in person, please contact Dr. Shirley Manly at 510-350-8577 or by email at shirleylampkin07@comcast.net.

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## About You

What is your age: \_\_\_\_\_ Are you Male \_\_\_\_\_ Female \_\_\_\_\_ LBGT \_\_\_\_\_

### What is your ethnic background? (Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> African American               | <input type="checkbox"/> Cuban                    | <input type="checkbox"/> Native American |
| <input type="checkbox"/> African Black                  | <input type="checkbox"/> Mexican/Mexican American | <input type="checkbox"/> White/Caucasian |
| <input type="checkbox"/> Other (non-Hispanic)           | <input type="checkbox"/> Caribbean Black          | <input type="checkbox"/> Latino/Hispanic |
| <input type="checkbox"/> Central America                | <input type="checkbox"/> Hispanic Black           | <input type="checkbox"/> Biracial        |
| <input type="checkbox"/> White/Caucasian (non-Hispanic) | <input type="checkbox"/> Other _____              |  |
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**The responses in this section tell us about your current living situation. What is the zip code and city or neighborhood where you live?** Zip Code \_\_\_\_\_

City /Neighborhood \_\_\_\_\_

### Where do you currently live? (Check One Box)

- |  |  |
|--|--|
| <input type="checkbox"/> In an apartment /house I own          | <input type="checkbox"/> In supportive living/assisted living facility                   |
| <input type="checkbox"/> In an apartment/house I rent          | <input type="checkbox"/> In a group home or residence including residential drug therapy |
| <input type="checkbox"/> Living/crashing with someone          | <input type="checkbox"/> In a half way house or transitional housing                     |
| <input type="checkbox"/> Single Room Occupancy with tenancy    | <input type="checkbox"/> Homeless (on the street/in a car)                               |
| <input type="checkbox"/> Single Room Occupancy without Tenancy | <input type="checkbox"/> Homeless (Shelter)  |
| <input type="checkbox"/> Jail or correction facility           | <input type="checkbox"/> Residential Hospice Facility                                    |
| <input type="checkbox"/> Other (Specify)                       |  |
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### Where do you get your health care? (Check all that apply and Name if known)

- Health Care Clinic \_\_\_\_\_
- Private Doctor \_\_\_\_\_
- Medical Center/Hospital \_\_\_\_\_

- Community Clinic\_\_\_\_\_
- Chiropractor/Alternative Practitioner\_\_\_\_\_
- Other\_\_\_\_\_

**In general, would you say your health is....**

- Excellent      Very Good      Good      Fair      Poor

**Compared to 6 months ago, how would you rate your health?**

- Much better than six months ago      Better now      About the same      Somewhat worse      Much worse

**What kind of health insurance do you have?**\_\_\_\_\_

- Insurance through work      Medicare-non HMO      Medicare HMO      COBRA (Insurance through last employer) Private insurance self pay Medi-Cal/Medi-Caid  Other Insurance
- \_\_\_\_\_
- None

**Have you or a family member been diagnosed by a physician as having (Check all that apply and include the year)**

	Yes	No	Family History	Don't Know	Year Diagnosed	Comment
Asthma, Emphysema or chronic bronchitis						
Arthritis						
Diabetes (Sugar)						
Cancer(what Type)						
Ulcers						
Osteoporosis						
High blood Pressure						
Heart Disease						
HIV/AIDS						
Glaucoma						
Heart Attack						
Stroke						
Peripheral Vascular Disease						
Other (Please Specify)						

**Do you remember your most recent cholesterol numbers**      Yes No what is your number\_\_\_\_\_

**Do you remember your most recent blood pressure**      Yes No what is your number\_\_\_\_\_

**Do you remember your most recent blood sugar**      Yes No what is your number\_\_\_\_\_

**What is your current weight/BMI** \_\_\_\_\_?      **How many days/week do you exercise?** 1 2 3 4 5 6 7

**How many servings of vegetables do you eat a week (circle one)** 1 2 3 4 5 6 7 8 greater than 8

**Do Smoke** Yes No If yes when was your last puff\_\_\_\_\_ Do you want help to stop smoking Yes No

**Do you drink alcohol** Yes No If yes when was your last drink\_\_\_\_\_ Do you want help to stop drinking Yes No

**Do you use drugs** Yes No If yes what type \_\_\_\_\_ Do you want help to stop using drugs Yes No

Have had any of the following screening test/procedures in the last year:( circle all that apply).

Mammogram	Colonoscopy	Blood Pressure	Hearing Test	Flu Shot
Clinical Breast Exam	DRE	EKG	Teeth Cleaning	Tetanus Shot
Bone Density	PSA	Cholesterol	Foot Exam	H1N1 Shot
Pap Test	HIV	Blood Sugar	Sigmoidoscopy	Pneumococcal Vaccine
Thyroid test	STI	Fecal Occult blood		

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Are you currently taking in medications Yes  No  Please list

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Would you be willing to participate in health screenings at Allen Temple? Yes  No  If so when should they be offered?

Day \_\_\_ Evening \_\_\_ Which day of the week \_\_\_M\_\_\_T\_\_\_W\_\_\_T\_\_\_F\_\_\_S\_\_\_S

Would you be willing to pay for services? Yes  No

Besides the screening tests, what other types of health services should we offer?

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Is there anything else you would like to share with us? \_\_\_\_\_

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