

## 2001 Tribal Health Survey Consent Form

**This is a health survey that has been requested by our Tribe, the X Tribe.** It has been created by Tribal Health Department staff, the Great Lakes Inter-Tribal Council Epidemiological Center Epidemiologist, X, and X. Tribal community members have pre-tested the survey to make sure that the survey asks good questions.

**It is important to us to protect your rights as both an individual and a tribal member.** Your confidentiality will be protected by tribal, local, state and federal laws. A number, not your name, will be used on your survey. Only XXX, the Tribal Health Director, will have access to a locked file containing the identifying information, which will not be released to anyone. If someone looks at your survey or answers, they will not be able to find out who you are. We will not be able to tell who you are by how you answer the questions.

**You and your answers are important to us.** Your answers will help our tribal health department figure out what the health needs of our Tribe are. Once all of the surveys are collected, we will look at the answers together. By comparing answers, we will have a good idea of what programs that you and the rest of the Tribe would like to see.

XXX, the Tribal Health Director, and the Tribal Health Department, can answer any questions and can be reached at 123-123-1234.

My signature below shows that I have received the 2001 Tribal Health Survey, and that I understand these questions are necessary to help develop programs to increase my health, and the health of my tribe. If I am uncomfortable with any of the survey questions, I may choose not to respond to it. However, I am encouraged to answer all questions. If at anytime I wish to discontinue, I may do so without explanation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_  
(Please Print)

Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
(If under 18)



7. By answering these questions, you will help us understand the vaccination status of our tribe.

HAVE YOU BEEN VACCINATED FOR:	Yes	No	Not Sure
a. Tetanus/diphtheria (Td) in the last ten years?	[ ]	[ ]	[ ]
b. Measles, Mumps, and Rubella (MMR) vaccine ever? (If your last vaccine was before 1960, please check No)	[ ]	[ ]	[ ]
c. Pneumonia (Pneumococcal) vaccine ever?	[ ]	[ ]	[ ]
d. 2 doses of Hepatitis A (HepA) vaccine ever?	[ ]	[ ]	[ ]
e. 3 doses of Hepatitis B (HepB) vaccine ever?	[ ]	[ ]	[ ]
f. The Flu virus (Influenza) in the last 12 months?	[ ]	[ ]	[ ]

**Questions About Your Health**

8. Have you ever been told by a doctor or a health professional you had the following conditions?

	Yes	No	Not Sure
a. A Heart Attack	[ ]	[ ]	[ ]
b. A Stroke	[ ]	[ ]	[ ]
c. Heart Disease	[ ]	[ ]	[ ]
d. Kidney Problems	[ ]	[ ]	[ ]
e. Lactose Intolerance (Inability to digest milk)	[ ]	[ ]	[ ]
f. Liver Disease/Failure	[ ]	[ ]	[ ]
g. Gallstones	[ ]	[ ]	[ ]
h. Depression	[ ]	[ ]	[ ]
i. Back Problems	[ ]	[ ]	[ ]
j. An Amputation	[ ]	[ ]	[ ]
k. Cancer	[ ]	[ ]	[ ]

l. If so, what type of cancer? \_\_\_\_\_

**Questions About Your Family's Health**

9. Have your Parents, Grandparents, Brothers, or Sisters ever had any of the following?

	Yes	No	Not Sure
a. A Heart Attack	[ ]	[ ]	[ ]
b. A Stroke	[ ]	[ ]	[ ]
c. Heart Disease	[ ]	[ ]	[ ]
d. Kidney Problems	[ ]	[ ]	[ ]
e. Lactose Intolerance (Inability to digest milk)	[ ]	[ ]	[ ]
f. Liver Disease/Failure	[ ]	[ ]	[ ]
g. Gallstones	[ ]	[ ]	[ ]
h. Depression	[ ]	[ ]	[ ]
i. Back Problems	[ ]	[ ]	[ ]
j. An Amputation	[ ]	[ ]	[ ]
k. Diabetes	[ ]	[ ]	[ ]

l. High Blood Pressure [ ] [ ] [ ]

m. Cancer [ ] [ ] [ ]

n. If so, what type of Cancer? \_\_\_\_\_

10. In the last 12 months have you had the flu? [ ] Yes  
[ ] No  
[ ] Not sure
11. In the last 12 months have you been to the dentist? [ ] Yes → **GO TO QUESTION 11a.**  
[ ] No → **GO TO QUESTION 11b.**
- 11a. Did you have cavities? [ ] Yes  
[ ] No
- 11b. Did any of your teeth hurt (ache)? [ ] Yes  
[ ] No
- 11c. Do you have complete set of false teeth (dentures)? [ ] Yes  
[ ] No  
(Please do not include partial dentures)

**FEELINGS:**

12. **The next seven questions are about feelings or thoughts people sometimes have. In the past week, how much of the time....**

	Never	A little of the time	Some of the time	Most of the time
a. Did you feel depressed?	[ ]	[ ]	[ ]	[ ]
b. Did you feel happy?	[ ]	[ ]	[ ]	[ ]
c. Did you feel you could not shake off the blues, even with help from your family or friends?	[ ]	[ ]	[ ]	[ ]
d. Did you feel lonely?	[ ]	[ ]	[ ]	[ ]
f. Did you feel that everything you did was an effort?	[ ]	[ ]	[ ]	[ ]
h. Did you have trouble keeping your mind on what you were doing?	[ ]	[ ]	[ ]	[ ]
g. Did you feel that you could not 'get going'?	[ ]	[ ]	[ ]	[ ]

**FAMILY: Please help us to understand the health of our children by answering the following questions.**

14. Are there children under 18 years of age living in your home?  YES → **CONTINUE WITH 12a.**  
 NO → **CONTINUE WITH 15.**

14a. How many children under 18 are you living with? \_\_\_\_\_ # children

14b. In the last year, have any of those children had dental care?  Yes  
 No  
 Not Sure

14c. In the last year, how many of those children had cavities? \_\_\_\_\_ # children  
 Not Sure

**How many of these children been vaccinated for:**

	Number of children vaccinated	None	Not Sure
14e. Tetanus/diphtheria (Td) in the last 10 years?	_____(#)	<input type="checkbox"/>	<input type="checkbox"/>
14f. Flu /Influenza in the last year?	_____(#)	<input type="checkbox"/>	<input type="checkbox"/>
14g. Measles/Mumps/Rubella (MMR) ever?	_____(#)	<input type="checkbox"/>	<input type="checkbox"/>
14h. Polio ever?	_____(#)	<input type="checkbox"/>	<input type="checkbox"/>
14i. 3 doses of Hepatitis B (HepB) vaccine ever?	_____(#)	<input type="checkbox"/>	<input type="checkbox"/>

**ALCOHOL USE: Please answer the following questions about alcohol consumption.**

15. Do you currently drink beer, wine, wine coolers, or hard liquor? (Any form of alcohol)  Yes → **GO TO QUESTION 15a.**  No → **GO TO QUESTION 16.**
- 15a. How often do you drink? (Check only one)  Daily  Once a week  4+ days a week  Once a month  2-3 days a week  Less than once a month
- 15b. When you drink, how many drinks do you usually have? \_\_\_\_\_ drinks 

1 drink= 1 beer <u>or</u> 1 shot of hard liquor <u>or</u> 1 small glass of wine <u>or</u> 1 wine cooler
--
- 15c. Which one do you drink the **most**? (Check only one)  Beer  Wine Coolers  Wine  Liquor
- 15d. Do you ever feel that you drink too much?  Yes  No
- 15d. Would you be interested in learning how to help control your drinking?  Yes → **GO TO QUESTION 17.**  No → **GO TO QUESTION 17.**
16. If you're not drinking alcohol now, did you drink alcohol in the past?  Yes → **GO TO QUESTION 16a.**  No → **GO TO QUESTION 17.**
- 16a. How often did you drink? (Check only one)  Daily  Once a week  4+ days a week  Once a month  2-3 days a week  Occasionally
- 16b. In the past, How many drinks a day would you have? \_\_\_\_\_ drinks 

1 drink= 1 beer <u>or</u> 1 shot of hard liquor <u>or</u> 1 small glass of wine <u>or</u> 1 wine cooler
--
- 16c. Which one did you drink the **most**? (Check only one)  Beer  Wine Coolers  Wine  Liquor
- 16d. How many years has it been since you quit drinking? \_\_\_\_\_ years





**Women Only: (Men Skip to question 24, top of page 9)**

23. The next several questions ask about health of the women in our Tribal community.

23a. At what age did you have your first menstrual period? \_\_\_\_\_ years old  
 Did not have one yet  
 Not sure how old

23b. Are you now or do you think you may be pregnant?  
 Yes  
 No  
 Not Sure

23c. Have you ever given birth to a child?  
 Yes → **GO TO QUESTION 23d.**  
 No → **GO TO QUESTION 23f.**

23d. How old were you when your first child was born? \_\_\_\_\_ years old  
 Not Sure

23e. How many children have you given birth to? \_\_\_\_\_ children  
(answer 0 if none)

23f. If you are pregnant or have had a child, did you ever receive prenatal care?  
 Yes → **GO TO QUESTION 23g.**  
 No → **GO TO QUESTION 23h.**  
 Not Sure → **GO TO QUESTION 23g.**  
 Never pregnant before → **GO TO QUESTION 23h.**

23g. How far along were you before you first had prenatal care? \_\_\_\_\_ Months or \_\_\_\_\_ Weeks  
(in months or weeks)  Never had prenatal care

23h. How long since your last: (Check One Box Per Line)

	Never	Under 1 yr	1 yr ago	2 yr ago	3+ yr ago	Not Sure
1. Pap smear?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Self-Breast exam?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Health Insurance and Services:** The next several questions ask about health care and your health needs. Please allow us to determine how we can help to better serve your needs by answering the following questions.

24. Where do you usually go when you are sick or need health care?  
(Check All That Apply)
- |  |   |
|--|---|
| <input type="checkbox"/> Emergency room          | <input type="checkbox"/> Indian Health Service        |
| <input type="checkbox"/> Doctors Office/Clinic   | <input type="checkbox"/> Urgent Care/Walk-in Clinic   |
| <input type="checkbox"/> Traditional Healer      | <input type="checkbox"/> Not Sure                     |
| <input type="checkbox"/> Local Health Department | <input type="checkbox"/> I usually do not go anywhere |

25. When you need health services, what are the reasons that you don't get them?  
(Check All That Apply)
- |   |   |
|---|---|
| <input type="checkbox"/> I always go when I'm sick  | <input type="checkbox"/> I don't have time    |
| <input type="checkbox"/> I do not like the facility | <input type="checkbox"/> I have no insurance  |
| <input type="checkbox"/> I don't have a car         | <input type="checkbox"/> I don't like doctors |
| <input type="checkbox"/> I can't drive              | <input type="checkbox"/> Other: _____         |

26. Contract Health is not insurance. It is a service offered through tribes, and can help pay for health care goods and services. Check the services that you have used Contract Health for in the last year:

- (Check All That Apply)
- |  |  |
|--|--|
| <input type="checkbox"/> Medical care  | <input type="checkbox"/> Counseling/Mental Health                    |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Assistance Devices (Wheel chairs, crutches) |
| <input type="checkbox"/> Hearing care  | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Dental Care   | <input type="checkbox"/> I haven't used Contract Health Service      |
| <input type="checkbox"/> Eye Care      | <input type="checkbox"/> Not Sure                                    |

27. Do you have medical insurance?
- |                              |                              |
|------------------------------|------------------------------|
| <input type="checkbox"/> Yes | → <b>GO TO QUESTION 27a.</b> |
| <input type="checkbox"/> No  | → <b>GO TO QUESTION 28</b>   |

- 27a. What types do you have?  
(Check All That Apply)
- |                                   |   |
|-----------------------------------|---|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Insurance through work                   |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> other private/non-governmental insurance |
| <input type="checkbox"/> HMO/PPO  | <input type="checkbox"/> Not Sure                                 |

- 27b. What does your health insurance cover?  
(Check All That Apply)
- |  |  |
|--|--|
| <input type="checkbox"/> Medical care  | <input type="checkbox"/> Counseling/Mental Health                    |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Assistance Devices (Wheel chairs, crutches) |
| <input type="checkbox"/> Hearing care  | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Dental Care   | <input type="checkbox"/> Not Sure                                    |
| <input type="checkbox"/> Eye care      |  |

28. In the LAST YEAR, what best described your medical needs? (Check All That Apply)
- |  |  |
|--|--|
| <input type="checkbox"/> Medical care  | <input type="checkbox"/> Counseling/Mental Health                    |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Assistance Devices (Wheel chairs, crutches) |
| <input type="checkbox"/> Hearing care  | <input type="checkbox"/> Other: _____                                |
| <input type="checkbox"/> Dental Care   |  |
| <input type="checkbox"/> Eye care      |  |

**Demographics:** This section will help us to understand other important factors in the designing of Tribal health programs.

29. What is your ethnicity? (Check All That Apply)
- |  |  |
|--|--|
| <input type="checkbox"/> Hispanic American | <input type="checkbox"/> Native American |
| <input type="checkbox"/> African American  | Tribe: _____                             |
| <input type="checkbox"/> Asian American    | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> European American |  |

30. What is your current marital status? (Check All That Apply)
- |   |   |
|---|---|
| <input type="checkbox"/> Living with boy/girlfriend | <input type="checkbox"/> Single/Never Married |
| <input type="checkbox"/> Single/Divorced            | <input type="checkbox"/> Married/First Time   |
| <input type="checkbox"/> Single/Widowed             | <input type="checkbox"/> Remarried            |

31. Education: What is the highest grade you completed? (Mark Only One)
- |   |  |
|---|--|
| <input type="checkbox"/> Grade School (1-8) or less | <input type="checkbox"/> College graduate              |
| <input type="checkbox"/> Some High School (9-11)    | <input type="checkbox"/> Post-Grad/Professional degree |
| <input type="checkbox"/> High School Graduate/GED   | <input type="checkbox"/> Not Sure                      |
| <input type="checkbox"/> Some College               |  |

32. Employment: What is your employment status? (Mark Only One)
- |  |  |
|--|--|
| <input type="checkbox"/> Retired             | <input type="checkbox"/> Self Employment               |
| <input type="checkbox"/> Non-working student | <input type="checkbox"/> Homemaker                     |
| <input type="checkbox"/> Working student     | <input type="checkbox"/> On disability/Unable to work  |
| <input type="checkbox"/> Employed- Part Time | <input type="checkbox"/> Unemployed less than 6 months |
| <input type="checkbox"/> Employed- Full Time | <input type="checkbox"/> Unemployed more than 6 months |

33. What county do you live in? \_\_\_\_\_ county

**Sanitation/Services:** Please help us determine what types of funding we need to secure to better serve your health needs by answering the next five questions.

34. At home, do you have city water or well water?       City       Well       Not Sure
35. Have you had your water tested in the last 3 years?       Yes       No       Not Sure
36. Do you have indoor plumbing?       Yes       No       Not Sure

37. Which would you use if available at an exercise facility? (CHECK ALL THAT APPLY)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Weight Room                 | <input type="checkbox"/> Personal Fitness Trainer  | <input type="checkbox"/> Martial Arts   |
| <input type="checkbox"/> Aerobics                    | <input type="checkbox"/> Nutritionist              | <input type="checkbox"/> Treadmills     |
| <input type="checkbox"/> Swimming Pool               | <input type="checkbox"/> Day Care while exercising | <input type="checkbox"/> other: _____   |
| <input type="checkbox"/> Basketball/Volleyball Court | <input type="checkbox"/> Transportation            | <input type="checkbox"/> Not interested |

38. How far would you travel if you had a FREE exercise facility available? \_\_\_\_\_ miles

**Tribal Opinions:**

39. In your opinion, which of these are health problems in our **TRIBE**?

Check Yes, if you think these are health problems in our Tribe.

Check No, if you **DO NOT** think that these are health problem in our Tribe.

Check Not Sure, if you think that it could be a problem or not in our Tribe, but are not certain.

<u>Yes</u>	<u>No</u>	<u>Not Sure</u>		<u>Yes</u>	<u>No</u>	<u>Not Sure</u>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Safe water supply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Understanding Prescription Medications
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Automobile crashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of exercise/sedentary lifestyles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health (example: depression)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease/Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol and drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unhealthy infants being born
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung disease/breathing problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fetal Alcohol Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental care
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Teen pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assisted living/Adult foster care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poisoning
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child abuse/Neglect
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

**As for all questions on this survey, your answers to the following questions are voluntary and confidential. Your answers will help us to understand important factors that influence our community's health. Your personal answers will not be reported in any way.**

40. What is your current annual household income
- |   |   |
|---|---|
| <input type="checkbox"/> \$ 0-10,000      | <input type="checkbox"/> \$ 40,001-50,000 |
| <input type="checkbox"/> \$ 10,000-20,000 | <input type="checkbox"/> \$ 50,001-60,000 |
| <input type="checkbox"/> \$ 20,001-30,000 | <input type="checkbox"/> \$ 60,001-70,000 |
| <input type="checkbox"/> \$ 30,001-40,000 | <input type="checkbox"/> \$ 70,001+       |
41. Have you ever had injuries caused by a family member, friend, or loved one?
- No  
 Yes, but not recently  
 Yes, within the last 2 months
42. Have you ever considered suicide?
- No  
 Yes, but not recently  
 Yes, within the last 2 months
43. Have you ever smoked marijuana?
- No  
 Yes, but not recently  
 Yes, within the last 2 months

**Please use this space below to write us regarding any health needs or concerns you have that have not been addressed by this survey. Please feel free to use the back of this form if you need more space**

Office use only(method) <input type="checkbox"/> Mail <input type="checkbox"/> Comm Meeting <input type="checkbox"/> Interview, home <input type="checkbox"/> Interview, central <input type="checkbox"/> Other: _____  Intials _____
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