Community Health Survey

INSTRUCTIONS | We invite you to participate in the 2013 Butte County Community Health Survey, providing information about your health, the health of your family and health issues facing our community. We are conducting this survey together with the Butte County Public Health Department, Biggs-Gridley Memorial Hospital, Enloe Medical Center and Feather River Hospital as part of a joint Community Health Needs Assessment.

The survey will take about 10 to 15 minutes to complete and will help us identify the unique health-related concerns facing residents throughout Butte County. It will also help us develop a series of activities to address the needs identified.

This is an anonymous survey and we want to assure you that your responses will be kept strictly confidential. If you do not wish to answer a question, or if a question does not apply to you, you may leave your answer blank.

SECTION 1: ABOUT YOUR HEALTH AND FAMILY

Check the boxes that best apply for you, your spouse or partner, and/or your child(ren)

PLEASE DESCRIBE YOUR HEIGHT AND WEIGHT

About how tall are you (without shoes)? _____

About how much do you weigh (without shoes)? _____

How would you describe the overall health of each member of your family?

Very good	☐ You	☐ Spouse/Partner	☐ Child(ren)
Good	☐ You	☐ Spouse/Partner	☐ Child(ren)
Fair	☐ You	☐ Spouse/Partner	☐ Child(ren)
Poor	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

Are you currently the primary caregiver for an ill or elderly family member?

☐ Yes ☐ No

Where do you and your family members receive routine health care services?

Private doctor's office	☐ You	☐ Spouse/Partner	☐ Child(ren)
Urgent/prompt care	☐ You	☐ Spouse/Partner	☐ Child(ren)
Emergency room	☐ You	☐ Spouse/Partner	☐ Child(ren)
Free/low-cost clinic	☐ You	☐ Spouse/Partner	☐ Child(ren)
School-based clinic	☐ You	☐ Spouse/Partner	☐ Child(ren)
Homeless shelter	☐ You	☐ Spouse/Partner	☐ Child(ren)
Store-based clinic	☐ You	☐ Spouse/Partner	☐ Child(ren)
No routine health care	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

Do you have a Primary Care Physician (PCP)?

Yes	☐ You	☐ Spouse/Partner	☐ Child(ren)
No	☐ You	☐ Spouse/Partner	☐ Child(ren)
Yes, but I don't see him/her regularly	☐ You	☐ Spouse/Partner	☐ Child(ren)

If you do not see a primary health provider regularly, please tell us why.

- ☐ I don't know how to find a good doctor
- ☐ I am uncomfortable with doctors
- ☐ My doctor has inconvenient hours
- ☐ Language, racial, or cultural barriers
- ☐ Lack of transportation
- ☐ It costs too much money
- ☐ Other _____

What other kinds of health care professionals do you visit regularly?

Medical specialist	☐ You	☐ Spouse/Partner	☐ Child(ren)
Dentist	☐ You	☐ Spouse/Partner	☐ Child(ren)
Eye doctor	☐ You	☐ Spouse/Partner	☐ Child(ren)
Mental health professional	☐ You	☐ Spouse/Partner	☐ Child(ren)
Home care nurse	☐ You	☐ Spouse/Partner	☐ Child(ren)
Spiritual healer	☐ You	☐ Spouse/Partner	☐ Child(ren)
Alternative healer (ex: Chiropractor)	☐ You	☐ Spouse/Partner	☐ Child(ren)

Next page ⇨

SECTION 1 CONTINUED...

Have you ever been told by a doctor or health care professional that a member of your family has any of these conditions, diseases or challenges?

Asthma	☐ You	☐ Spouse/Partner	☐ Child(ren)
Cancer	☐ You	☐ Spouse/Partner	☐ Child(ren)
Diabetes	☐ You	☐ Spouse/Partner	☐ Child(ren)
Heart Disease	☐ You	☐ Spouse/Partner	☐ Child(ren)
Substance Abuse	☐ You	☐ Spouse/Partner	☐ Child(ren)
Overweight/Obesity	☐ You	☐ Spouse/Partner	☐ Child(ren)
Eating Disorder	☐ You	☐ Spouse/Partner	☐ Child(ren)
Genetic Disorder	☐ You	☐ Spouse/Partner	☐ Child(ren)
Birth Defect	☐ You	☐ Spouse/Partner	☐ Child(ren)
Mental/Emotional Condition (inlcuding Depression)	☐ You	☐ Spouse/Partner	☐ Child(ren)
Developmental/Learning Concerns (including Autism)	☐ You	☐ Spouse/Partner	☐ Child(ren)

FOR WOMEN ONLY:

How long has it been since your last mammogram *(a screening exam for breast cancer)?*

☐ Within 1 year ☐ Within 2 years ☐ Within 3 years
☐ Within 4 years ☐ 5 or more years ☐ Never
☐ Not sure

How long has it been since your last pap smear *(a screening exam for cervical cancer)?*

☐ Within 1 year ☐ Within 2 years ☐ Within 3 years
☐ Within 4 years ☐ 5 or more years ☐ Never
☐ Not sure

Have you ever had a bone density scan *(a screening exam for osteoporosis)?*

☐ Yes ☐ No ☐ Not sure

FOR MEN ONLY:

How long has it been since your last rectal exam *(a screening used to examine the prostate)?*

☐ Within 1 year ☐ Within 2 years ☐ Within 3 years
☐ Within 4 years ☐ 5 or more years ☐ Never
☐ Not sure

How long has it been since you had a prostate cancer screening blood test?

☐ Within 1 year ☐ Within 2 years ☐ Within 3 years
☐ Within 4 years ☐ 5 or more years ☐ Never
☐ Not sure

FOR MEN AND WOMEN, AGE 50 AND OVER:

How long has it been since your last colonoscopy *(a screening exam for colon cancer)?*

☐ Within 1 year ☐ Within 2 years ☐ Within 5 years
☐ Within 10 years ☐ Over 10 years ☐ Never
☐ Not sure

How long has it been since your last sigmoidoscopy *(a screening exam for colorectal cancer)?*

☐ Within 1 year ☐ Within 2 years ☐ Within 5 years
☐ Within 10 years ☐ Over 10 years ☐ Never
☐ Not sure

ABOUT YOUR HEALTH COVERAGE:

Did you have health insurance during all, part or none of the past year?

All year	☐ You	☐ Spouse/Partner	☐ Child(ren)
Part of the year	☐ You	☐ Spouse/Partner	☐ Child(ren)
No insurance all year	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

Currently, what is your primary type of health care coverage?

Employer-sponsored plan	☐ You	☐ Spouse/Partner	☐ Child(ren)
Private insurance	☐ You	☐ Spouse/Partner	☐ Child(ren)
Medicare	☐ You	☐ Spouse/Partner	☐ Child(ren)
Medi-cal	☐ You	☐ Spouse/Partner	☐ Child(ren)
No health insurance	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

Do you have an advance care plan, living will or health care power of attorney?

Yes	☐ You	☐ Spouse/Partner	☐ Child(ren)
No	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

Next page ⇨

SECTION 2: ABOUT YOUR LIFESTYLE

Please answer each question based on the past year. Check the boxes that best apply for you, your spouse or partner, and/or your child(ren).

On average, how many servings of fruit do you eat or drink daily?
NOTE: one serving is 1/2 cup of canned or cooked fruit, 1 medium piece of fruit or 6 ounces of juice

3 or more servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
2 servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
1 or fewer servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

On average, how many servings of vegetables do you eat or drink daily?
NOTE: one serving is 1/2 cup of cooked or raw vegetable or 6 ounces of juice

3 or more servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
2 servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
1 or fewer servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

On average, how many sugar-sweetened beverages do you drink daily?
NOTE: include sodas, energy drinks, less than 100% juice drinks, etc.

3 or more servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
2 servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
1 or fewer servings	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

On average, how many days per week do you get at least 30 minutes of exercise or other physical activity?
EXAMPLES: walking, running, weight-lifting, team sports or gardening

5-7 days	☐ You	☐ Spouse/Partner	☐ Child(ren)
3-4 days	☐ You	☐ Spouse/Partner	☐ Child(ren)
1-2 days	☐ You	☐ Spouse/Partner	☐ Child(ren)
Only occasionally	☐ You	☐ Spouse/Partner	☐ Child(ren)

What obstacles prevent you from getting regular exercise?
(check all that apply)

- ☐ Not enough time in my day
- ☐ I don't know how to properly exercise
- ☐ I don't know where to go for exercise
- ☐ I'm not healthy enough to exercise
- ☐ It's hard to stay motivated
- ☐ Not sure

How often do you wear a helmet when riding a bicycle, skateboard or scooter?

Always	☐ You	☐ Spouse/Partner	☐ Child(ren)
Nearly always	☐ You	☐ Spouse/Partner	☐ Child(ren)
Sometimes	☐ You	☐ Spouse/Partner	☐ Child(ren)
Seldom	☐ You	☐ Spouse/Partner	☐ Child(ren)
Never	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

How often do you wear a seat belt when driving or riding in a car?

Always	☐ You	☐ Spouse/Partner	☐ Child(ren)
Nearly always	☐ You	☐ Spouse/Partner	☐ Child(ren)
Sometimes	☐ You	☐ Spouse/Partner	☐ Child(ren)
Seldom	☐ You	☐ Spouse/Partner	☐ Child(ren)
Never	☐ You	☐ Spouse/Partner	☐ Child(ren)
Not sure	☐ You	☐ Spouse/Partner	☐ Child(ren)

How many days per week do you drink alcoholic beverages?

☐ None ☐ 1-2 days ☐ 3-4 days
☐ 5 or more days ☐ Not sure

If you do drink, how many drinks might you have at one time?

☐ 1 drink ☐ 2 drinks ☐ 3 drinks
☐ 4 or more drinks ☐ Not sure ☐ I don't drink alcohol

How often do you smoke cigarettes or use other forms of tobacco?

☐ Never ☐ 1-2 days ☐ 3-4 days
☐ 5 or more days ☐ Not sure

If you smoke, have you tried to quit?

☐ Yes, I quit ☐ Yes, I started again
☐ No, I still smoke ☐ I don't smoke

How often would you say you feel sad, blue or depressed?

☐ Never ☐ Seldom ☐ Sometimes
☐ Often ☐ Always ☐ Not sure

Have you considered suicide?

☐ Yes ☐ No ☐ Not sure

Next page ⇨

SECTION 2 CONTINUED... Please answer each question based on the past year.

Has anyone made you feel afraid for your personal safety or physically hurt you?

☐ Yes ☐ No ☐ Not sure

If yes, what relationship is this person (or people) to you?

☐ Stranger ☐ Friend ☐ Spouse
☐ Boyfriend/Girlfriend ☐ Ex-spouse ☐ Separated spouse
☐ Acquaintance ☐ Other

SECTION 3: ABOUT YOUR COMMUNITY'S HEALTH

Please select your TOP THREE answers for each of the following:

Most important factors for a "Healthy Community"

☐ Low crime/safe neighborhoods
☐ Good schools
☐ Access to affordable health care
☐ Lots of parks & recreation opportunities
☐ Affordable housing
☐ Good jobs/Healthy economy
☐ Healthy behaviors and lifestyles
☐ Clean environment
☐ Access to affordable fresh/natural foods
☐ Access to mental health services
☐ Access to substance abuse programs/support

Greatest needs affecting "Children's Health"

☐ Access to immunizations
☐ Access to health care services
☐ Access to mental health services
☐ Access to affordable fresh/natural foods
☐ Affordable healthy lifestyle programs
☐ Affordable health insurance
☐ Affordable services for special needs
☐ Better school-lunch programs
☐ Better child/day care options
☐ Access to free health screenings
☐ Lack of physical activity
☐ Safe places to play

Most important "Health Problems" facing our community

☐ Cancer
☐ Diabetes
☐ Heart Disease/High Blood Pressure
☐ Stroke
☐ Obesity
☐ Mental Health Issues
☐ Respiratory/Lung Disease
☐ Dental Hygiene
☐ Sexually Transmitted Diseases (STDs)
☐ Suicide
☐ Teen pregnancy
☐ Infectious Diseases (ex: Hepatitis, TB)
☐ Shortage of Primary Care Doctors

Most challenging "Risky Behaviors" facing our community

☐ Alcohol abuse
☐ Drug abuse
☐ Driving while under the influence
☐ Tobacco use/secondhand smoke
☐ Child abuse/neglect
☐ Lack of exercise
☐ Poor eating habits
☐ Dropping out of school
☐ Not wearing a helmet
☐ Not wearing a seat belt

SECTION 4: ABOUT YOU AND WHERE YOU LIVE

Check the box that best applies.

Where did you learn about this survey?

☐ At the hospital ☐ From my doctor
☐ At my church ☐ At a community meeting
☐ At a health fair ☐ At a retail store
☐ From a friend ☐ At work
☐ Online ☐ Other _____

Which hospital do you normally go to for care?

☐ Biggs-Gridley Memorial Hospital
☐ Enloe Medical Center
☐ Feather River Hospital
☐ Oroville Hospital
☐ Other _____

Next page ⇨

SECTION 4 CONTINUED... Please check the box that best applies

What is your home zip code? _____

Your gender: ☐ Female ☐ Male

Your age: ☐ 25 or less ☐ 26-39 ☐ 40-54 ☐ 55-64 ☐ 65 or over

What is your race?

☐ White
☐ Black, African American
☐ Native Hawaiian/Other Pacific Islander
☐ Asian
☐ American Indian/Alaska Native
☐ Hispanic/Latino
☐ No answer

What is your marital status?

☐ Single/Never Married
☐ Married
☐ Divorced
☐ Unmarried Couple
☐ Separated
☐ Widowed
☐ No answer

Do you have children currently living in your household?

☐ Yes, under 18 years old
☐ Yes, 18 years or older
☐ Both of the above
☐ No children living at home

What is the highest level of education you have completed?

☐ Elementary School
☐ Middle School
☐ High School
☐ Some College
☐ Associate Degree
☐ Bachelor's Degree
☐ Graduate School
☐ Technical/Trade School
☐ Union Apprenticeship
☐ Other _____

What is your current employment status? *(check all that apply)*

☐ Full-time
☐ Part-time
☐ Unemployed
☐ Self-Employed
☐ Homemaker
☐ Student
☐ Retired
☐ No answer

What is your annual household income before taxes?

☐ Less than $30,000
☐ $30,000 to $60,000
☐ $60,001 to $90,000
☐ $90,001 to $120,000
☐ Over $120,000
☐ Not sure
☐ No answer

How would you prefer to access your personal health information? *(check all that apply)*

☐ Paper Copy ☐ Online ☐ Mobile Device

How would you prefer to receive health information? *(check all that apply)*

☐ Traditional Mail ☐ Email ☐ Text

IS THERE ANYTHING WE'VE OVERLOOKED?

Feel free to write in additional information you think we should know about the health of our community.

_____

_____

_____

_____

Thank you for your time!

Your anonymous responses will be used by the Butte County hospitals, Butte County Public Health Department and other local organizations to better serve the health needs of our community's resident. Please mail your completed survey in the attached envelope. No postage is required.