

# Under 15 Community Health Assessment Paper

## Madison County Community Health Assessment

Thank you for taking time to complete the 2011 Madison County Community Health Assessment Survey!

Responses from this survey will be used by the Madison County Health Department and Madison Community Health Consortium to help address the major health and community issues in Madison County, North Carolina.

The survey questions will ask your opinion about local health strengths, needs, and concerns.

The survey will take approximately 15 minutes to complete and your opinion matters!

## How does the survey work?

All the information you provide for this survey is kept confidential and you will not be asked to provide your name or any other identifying information.

Please answer every question to the best of your ability. Any special instructions are located at the beginning of a section.

If you do not live in Madison County, North Carolina we ask that you do not complete this survey.

If you have any questions, please contact us at [dstephens@madisoncountync.org](mailto:dstephens@madisoncountync.org) or call 828-649-3531, ext. 240

## Part I Information About You

This information tells us about you and remember, all information remains confidential.

### 1. What is your age?

- |                          |                          |
|--------------------------|--------------------------|
| <input type="radio"/> 9  | <input type="radio"/> 12 |
| <input type="radio"/> 10 | <input type="radio"/> 13 |
| <input type="radio"/> 11 | <input type="radio"/> 14 |

### 2. Are you:

- Male
- Female

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## 3. What is your race?

- White, non-Hispanic
- Black or African American
- Hispanic/Latino
- American Indian or Alaska Native
- Asian/Pacific Islander
- Other (please specify)

## 4. What grade are you in?

- 3rd grade
- 4th grade
- 5th grade
- 6th grade
- 7th grade
- 8th grade
- 9th grade
- Other (please specify)

## 5. Number of people living in your home:

Adults

Children under 18 years of age

## 6. Madison County Resident:

For how many years?

Name of Community?

## Part II Personal Health Information

This section will tell us about your health and how you rate your health status.

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## 7. How would you rate your own personal health?

- Excellent/Very Healthy
- Very Good/Healthy
- Good/Somewhat Healthy
- Fair/Unhealthy
- Poor/Very Unhealthy
- Don't Know/Not Sure

## 8. When did you last visit a doctor for a ROUTINE checkup?

- Within the last year
- 1-2 years ago
- 3-5 years ago
- 5 or more years ago
- Never

## 9. Where do you go MOST OFTEN when you are sick?

- Doctor's Office
- Health Department
- School Based Health Clinic (Patriot Place)
- Hospital Emergency Room
- Chiropractor
- Alternative Medicine Provider (Herbalist/Accupuncture, etc)
- Other (please specify)

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## 10. Have you ever been told by a health professional that you have any of the following?

	Yes	No	Don't Know
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental Problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression/Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other Mental Health Problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes (not during pregnancy)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart Disease/Angina	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hearing Problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Learning/Developmental Disability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lung Disease (COPD)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overweight/Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vision Problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## 11. On average, how often do you exercise?

- More than 5 times per week
- 4-5 times per week
- 2-3 times per week
- 1 time per week
- Not at all

## 12. Each time you exercise, indicate for how long.

- 15-20 minutes
- 25-45 minutes
- 50 - 60 minutes
- More than an hour

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### 13. What kind of exercise? (Check all that apply)

- Hiking/Walking
- Jogging
- Running
- Biking
- Group Sports (tennis, basketball, etc)
- Home Equipment (treadmill, etc.)
- Swimming
- Aerobics
- Other (please specify)

### 14. If you don't exercise, why not? Check all that apply.

- Exercise is not important
- Don't like to exercise
- Too tired to exercise
- Not enough time to exercise
- Costs too much
- No safe place to exercise
- Don't have access to a facility/facility too far from home
- Physically disabled
- Unaware of physical activity options in the community
- Other (please specify)

### 15. On average, how often do you eat fast food (McDonald's, etc)?

- 1-2 times per week
- 3-5 times per week
- Daily
- Hardly ever

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## 16. How many times per week do you eat fresh fruits or vegetables?

- Daily
- 2-3 times/week
- 4-5 times/week
- Hardly ever

## 17. Do you currently use any type of tobacco product?

- Yes, cigarettes, pipe, cigars
- Yes, smokeless tobacco
- Yes, both smoked and smokeless tobacco
- No

## 18. Have you or a family member been exposed to secondhand smoke in the past year at any of the following locations? Check all that apply

- |   |   |
|---|---|
| <input type="checkbox"/> Home                   | <input type="checkbox"/> Restaurants                          |
| <input type="checkbox"/> Workplace              | <input type="checkbox"/> Car                                  |
| <input type="checkbox"/> Hospital               | <input type="checkbox"/> I am not exposed to secondhand smoke |
| <input type="checkbox"/> School                 |   |
| <input type="checkbox"/> Other (please specify) |   |

## 19. Do you currently drink alcohol?

- Yes
- No

## 20. In the past 12 months have you or your family ever felt threatened?

	Yes	No
At home	<input type="radio"/>	<input type="radio"/>
At school	<input type="radio"/>	<input type="radio"/>
At work	<input type="radio"/>	<input type="radio"/>
In the community	<input type="radio"/>	<input type="radio"/>

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## Part III Emergency Preparedness

Tell us about your state of preparedness.

### 21. In a large scale disaster affecting your community, where would you likely look for information? Check all that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Parents/Family          | <input type="checkbox"/> Social Media Site (Facebook, MySpace)       |
| <input type="checkbox"/> TV                      | <input type="checkbox"/> Emergency Alert System call or text message |
| <input type="checkbox"/> Internet                | <input type="checkbox"/> School/ConnectEd Messaging                  |
| <input type="checkbox"/> Radio                   | <input type="checkbox"/> Neighbors                                   |
| <input type="checkbox"/> Print Media (newspaper) | <input type="checkbox"/> Don't know/Not Sure                         |

Other (please specify)

### 22. Do you have a plan for how to communicate with family members in the event of an emergency and everyone is away from home?

- Yes  
 No

### 23. Does your school have an emergency preparedness plan?

- Yes  
 No  
 Don't Know

## Part IV Community Health Information

The following question asks about the health and community issues in Madison County. Tell us how you would rate each one.

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## 24. Please tell us about how the following issues might be of concern to you.

**Great: A high concern**

**Moderate: Somewhat of a concern**

**N/A: Not a concern**

	Great	Moderate	N/A
Teen pregnancy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexually transmitted Diseases (STDs)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Availability of healthy food choices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity/Overweight	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lack of tobacco-free environments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Abuse/Neglect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Violent crime (assault/rape/murder)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suicide	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Inadequate sidewalks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unsafe/poorly maintained roads	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reckless driving/speeding/DWI	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Theft/ID Theft, other similar crimes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Air pollution	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Water pollution	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Land Pollution	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sewage on property	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Contaminated streams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unsafe drinking water	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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## 25. Do you need more information about the following issues? Check all that apply

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma Management                  | <input type="checkbox"/> Alcohol use                           |
| <input type="checkbox"/> Diabetes Management                | <input type="checkbox"/> Drug use/K2/Spice                     |
| <input type="checkbox"/> Dental Hygiene                     | <input type="checkbox"/> Internet safety                       |
| <input type="checkbox"/> Nutrition                          | <input type="checkbox"/> Bullying/Cyber bullying               |
| <input type="checkbox"/> Eating Disorders                   | <input type="checkbox"/> Cell Phone safety/Sexting             |
| <input type="checkbox"/> Overweight/Obesity                 | <input type="checkbox"/> Social Media Safety/Facebook          |
| <input type="checkbox"/> Ways to increase physical activity | <input type="checkbox"/> Sexual activity                       |
| <input type="checkbox"/> Reckless driving/speeding          | <input type="checkbox"/> Teen pregnancy                        |
| <input type="checkbox"/> Choking game                       | <input type="checkbox"/> Dating violence                       |
| <input type="checkbox"/> Suicide prevention                 | <input type="checkbox"/> Sexually Transmitted Disease (STD)    |
| <input type="checkbox"/> Mental Health issues               | <input type="checkbox"/> HIV                                   |
| <input type="checkbox"/> Tobacco use                        | <input type="checkbox"/> My children have adequate information |
| <input type="checkbox"/> Other (please specify)             |  |

## 26. Do you feel comfortable talking to your parents about risky health behaviors?

- Yes  
 No  
 Don't Know

## 27. Where would you most likely look for health care information?

- |   |  |
|---|--|
| <input type="checkbox"/> Parents                | <input type="checkbox"/> Pharmacist      |
| <input type="checkbox"/> TV                     | <input type="checkbox"/> School          |
| <input type="checkbox"/> Newspaper              | <input type="checkbox"/> Church          |
| <input type="checkbox"/> Radio                  | <input type="checkbox"/> Friends/Family  |
| <input type="checkbox"/> Internet               | <input type="checkbox"/> Neighbors       |
| <input type="checkbox"/> Doctor/Nurse           | <input type="checkbox"/> Help Lines      |
| <input type="checkbox"/> Health Department      | <input type="checkbox"/> Books/Magazines |
| <input type="checkbox"/> Hospital               |  |
| <input type="checkbox"/> Other (please specify) |  |

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## Thank You!

We appreciate that you have completed this survey.

Your Opinion Matters!

Madison County Health Department will use this survey information to help address the health issues facing the county.