

**Bloomington Township Community Health Needs Assessment-
PAPER SURVEY**

Welcome to the Survey!

Thank you for your willingness to take the **Bloomington Township Community Health Needs Assessment Survey**. We are interested in learning about our community to help **the Bloomington Township Mental Health Board** better understand the community's health needs.

This survey is anonymous and confidential! We will not ask for your name or any information that might identify you. All the results will be looked at together and reported as a whole. **If you do not wish to answer a question, you may skip it.**

The survey is expected to take 10-15 minutes to complete.

When you have completed the survey, place and seal it in the envelope given to you and return it to the site or person/office who gave you the survey or the Township office located at 123 Rosedale Ave. in Bloomington (630) 529-7715.

ELIGIBILITY (PUT AN X NEXT TO YOUR ANSWER)

1. In which of the following communities in Bloomington Township do you live.

- Addison
- Bloomington
- Carol Stream
- Glendale Heights
- Hanover Park
- Itasca
- Lombard
- Roselle
- Winfield
- Cloverdale
- Keeneyville
- Medinah
- Swift
- Glen Ellyn/Countryside

2. Are you 18 years of age or older?

YES

NO

HEALTHCARE (PUT AN X NEXT TO YOUR ANSWER)

3. Where do you or members of your immediate family usually go for your medical health care needs

Doctor's office or private clinic?

Community Health Center or Other Public Clinic

Hospital Emergency Room?

College or university health clinic?

Clinic located within a Walgreens, CVS, etc.

Immediate or Urgent Care Center?

Other? Please specify-

4. What kind of health insurance do you have?

None/uninsured

Medicaid

Medicare

Veteran's Administration or Indian Health Service Coverage

Private insurance through my job or job of a family member

Other Please Specify?

5. During the past 12 months, have you or a member of your family delayed getting needed medical care?

Yes

No

Don't know/not sure

6. If you have delayed getting needed medical care, what was the most important reason?

Not Applicable

I couldn't afford the medical care

I did not have insurance that covered the needed care

Deductible too high

I couldn't get through on the telephone.

I did not know who to call

I could not get an appointment soon enough

Once I got there, I had to wait too long to see the doctor.

The clinic/doctor's office was not open when I got there.

I did not have transportation

Other (please specify)

7. During the past 12 months, have you delayed in getting a needed prescription?

Yes

No

Don't know/not sure

8. If you have delayed in getting a needed prescriptions, what was the most important reason?

Not Applicable

I could not afford the cost of filling the prescription.

- The prescription was not covered by health insurance.
- I was worried about the side effects or drug interactions.
- I did not think the medicine was needed for my condition.
- There is no pharmacy close to where I work or live
- Other (please specify)

HEALTH INFORMATION (PUT AN X NEXT TO YOUR ANSWER)

9. How confident are you filling out medical forms by yourself?

- | | | | | |
|-----------|----------|----------|------------|----------|
| 1 | 2 | 3 | 4 | 5 |
| Extremely | | | Not At All | |

10. How often do you have someone help you read health or medical materials?

- | | | | | |
|----------|----------|----------|----------|----------|
| 1 | 2 | 3 | 4 | 5 |
| Never | | | Always | |

11. Where do you go to find information about your health (including behavioral or mental health information)? **Select all that apply.**

- Friends and family
- The internet/websites (WebMD, Mayo Clinic, government website, etc.)
- Media other than the internet
- School
- Church/faith community
- Physician/health professional
- Other (Please specify)

PHYSICAL HEALTH AND CHRONIC HEALTH CONDITIONS

12. Overall, how would you rate your physical health?

- | | | | | |
|----------|----------|----------|----------|----------|
| 1 | 2 | 3 | 4 | 5 |
|----------|----------|----------|----------|----------|

Excellent

Poor

13. Have you or an immediate family member ever been told by a doctor, nurse or other health professional that you have any of the of the following chronic physical health conditions? **Please select all that apply.**

Epilepsy

Stroke

Parkinson Disease

Multiple sclerosis

Dementia/Alzheimer's Disease

None

Other **Please specify?** _____

14. How are you or your immediate family member managing the condition(s)?

Select all that apply.

Not Applicable/No longer suffer from the health condition

Medication

Diet

Physical activity

Alternate Therapies

Physical Therapy

Surgery

I am not/my family member is not managing the condition

Other (**Please Specify**) _____

15. How much does the chronic health condition interfere with usual daily activities?

1

2

3

4

5

Never

Always

ALCOHOL

16. During the past 30 days, on how many days did you have at least one drink containing alcohol? ***If 0 days, please select 0 days and skip to question #26***

- 0 Days
- 1 or 2 Days
- 3 to 5 Days
- 6 to 9 Days
- 10 to 19 Days
- 20 to 29 Days
- All 30 Days

17. During the past 30 days, on the days you drank alcohol, how many drinks did you usually drink per day?

- 1
- 2-3
- 4-5
- 6 or more

MENTAL HEALTH

18. In general, how would you rate your current mental health?

1 2 3 4 5

Excellent

Poor

19. In the past twelve months, have you or a family member experienced any mental health issues which have caused significant distress (e.g. depressions, stress, family problems, substance use problems). ***If no please select no and skip to question #30.***

- Yes
- No
- Don't know/not sure

20. In the past 12 months have ***you or a member of your household*** experienced any of the mental health issues, which caused significant distress. ***Check all that apply.***

- Depression/feeling sad, blue, or depressed for more than two weeks
- Depression/feeling sad, blue, or depressed for more than two weeks after the birth of a child.
- Anxiety or excessive worry
- Post-traumatic stress disorder
- Bipolar disorder (mood swings from very high to very depressed)
- Feeling suicidal
- Oppositional or defiant behavior
- Sleep Disorder
- Hoarding
- Not able to manage stress
- Attention disorder and/or hyperactivity
- Thought Disorder (e.g. schizophrenia or psychosis)
- Anger management or trouble controlling violent behavior (including verbal, physical abuse)
- Problems with thinking or remembering
- Problems with alcohol use
- Obsessive-compulsive problems (e.g. checking, washing or other rituals)
- Unable to stop smoking when you wanted to
- Problems with drug use (including recreational drugs or prescription medications)
- Marital or romantic relationship problems
- Family problems
- Compulsive behavior (e.g. gambling, internet use, shopping, but not with alcohol or drugs)
- Bereavement or coping with a death
- Sexual problems
- Sexual assault
- Victim of a crime
- Domestic violence
- Mental health emergency/crisis
- Attempted suicide
- Non-suicidal self-injury
- Panic Attacks
- None

Other (*Please specify*) _____

21. Which member (s) of your household experienced these issues? **Check all that apply.**

 Self

 Spouse/partner

 Young child (under 12)

 Adolescent child (12-19)

 Adult child (over 20)

 Other (*Please specify*) _____

22. If you experienced a mental health condition in the past 12 months, how much did it interfere with your usual daily activities?

1

2

3

4

5

Never

Always

23. If another household member experienced a mental health condition in the past 12 months, how much did it interfere with their usual daily routines?

1

2

3

4

5

Never

Always

24. Did you or your household member seek help for a mental health condition?

 Yes

 No

25. If you or your household member sought help for a mental health condition(s) what kind (s) of help did you seek? **Mark all that apply.**

 Not Applicable

 Psychiatric medications

 Support group/self-help group

 Individual counseling/therapy

 Intensive outpatient treatment

 Religious counseling (e.g. from pastor, priest, rabbi, imam)

 School-based therapy

 Group therapy

- Family therapy
- Parenting training
- Help-line (like tobacco quit-line)
- Domestic violence services
- 12 step group (e.g. AA, NA, SA)
- Hospital inpatient treatment
- Residential treatment
- Respite services
- On-line advice or on-line support group
- Alternative therapies (acupuncture, herbal supplements, hypnosis, etc.)
- Police or fire emergency services
- Other (*please specify*) _____

26. If you or a household member did not seek needed services, which of the following have kept you/your family member from getting needed services? **Mark all that apply.**

- Not Applicable
- Didn't know where to go for services
- Cost of treatment
- Concern about privacy or confidentiality
- Lack of insurance/insurance does not cover cost of behavioral health treatment
- Transportation to get to services
- Agencies did not understand my language/culture
- No agency has the services I need
- The wait for help is too long
- A Family member prevented me from seeking services.
- Others might have a negative view of me for using such services.
- Fear of having to take medicine or be committed to a hospital
- Other (*please specify*) _____

27. If you or a member of your household received help in the past 12 months for a behavioral health condition, where did you receive help? **Mark all that apply.**

- Private practice/practitioner
- Alexian Brothers Hospital
- Glen Oaks Hospital

- NAMI
- DuPage County Health Department
- Bloomingdale Township Youth Services
- Kenneth Young Center
- Russo Center
- Hamdard Center
- YWCA
- Serenity House
- Bridge Community
- Rosecrance
- Central DuPage Hospital
- Linden Oaks
- Social Worker/School Counselor
- Other (*please specify*) _____

28. If you or a household member received services for a mental health condition, please indicate your agreement with following statements.

I would recommend this service to a friend.

1	2	3	4	5
Strongly Agree				Strongly Disagree

The providers were knowledgeable about the problem and offered appropriate treatment

1	2	3	4	5
Strongly Agree				Strongly Disagree

The mental health condition has improved.

1	2	3	4	5
Strongly Agree				Strongly Disagree

No

34. If you or your household member sought help for a developmental condition, what kinds of help did you seek? **Mark all that apply.**

Not Applicable (did not seek help)

Medication

Individual therapy

Early intervention services

Group or family therapy

School-based services

Support group/self-help group

Vocational assistance

Hospital services

Residential services (e.g., supported living arrangement)

Respite services

Other **Please Specify** _____

35. If you or a household member did not seek needed services, which of the following have kept you/your family member from getting needed services? **Mark all that apply.**

Not Applicable

Didn't know where to go for services

Cost of treatment

Concern about privacy or confidentiality

Lack of insurance/insurance does not cover cost of behavioral health treatment

Transportation to get to services

Agencies did not understand my language/culture

No agency has the services I needed

The wait for help is too long

A Family member prevented me from seeking services

Others might have a negative view of me for using such services

Fear of having to take medicine or be committed to a hospital

Other (**please specify**) _____

36.If you or a member of your household received help in the past 12 months for a developmental health condition, where did you receive help? **Mark all that apply.**

- Private practice/practitioner
- Alexian Brothers Hospital
- Glen Oaks Hospital
- NAMI
- DuPage County Health Department
- Easter Seals
- Ray Graham
- WEDSRA
- NEDSRA
- Marklund
- School Counselor/Social Worker
- Other (*please specify*) _____

37.If you or a household member received services for a developmental condition, please indicate your agreement with following statements.

I would recommend this service to a friend.

1	2	3	4	5
Strongly				Strongly
Agree				Disagree

The providers were knowledgeable about the problem and offered appropriate treatment

1	2	3	4	5
Strongly				Strongly
Agree				Disagree

The condition has improved.

1	2	3	4	5
Strongly				Strongly
Agree				Disagree

43. If you or your household member sought outside help, where was it sought?

Mark all that apply.

- Not Applicable (did not seek help)
- Clergy/Priest/Imam
- Police
- Mental Health Professional/Counselor
- Group or family therapy
- Relative/Neighbor/Friend
- Physician
- Emergency Room or Urgent Care Center
- Internet online information or support group
- YWCA
- Stepping Stones
- Bridge Community
- Other (*Please specify*) _____

44. How effective was this in resolving you or your family member's domestic abuse issue?

1 2 3 4 5

Extremely

Not At All

QUALITY OF LIFE

45. In the past 12 months, how often did you or your family worry about whether your food would run out before you had the money to buy more?

1 2 3 4 5

Frequently

Never

46. Do you currently participate in the Supplemental Nutrition Assistance Program (also known as Illinois Link Card, SNAP, or food stamps)?

- Yes
- No
- Don't know/not sure

47. Do you currently participate in the Special Supplemental Nutrition Program for Women, Infants and Children program (also known as WIC)

Yes

No

Don't know/not sure

YOUR COMMUNITY'S HEALTH

48. How would you rate your community on each item below?

How available are programs or activities for teens and youth during non-school hours?

1 2 3 4 5

Extremely

Not At All

49. Please rate the following items related to public transportation in your community.

Availability of public transportation

1 2 3 4 5

Excellent

Very Poor

Reliability of public transportation

1 2 3 4 5

Excellent

Very Poor

Affordability of public transportation

1 2 3 4 5

Excellent

Very Poor

Quality and convenience of bike lanes

1 2 3 4 5

Excellent

Very Poor

Quality of sidewalks

1 2 3 4 5

Excellent

Very Poor

ADA accessibility

1 2 3 4 5

Excellent

Very Poor

50. What do you believe are the five (5) most important factors for a community to be healthy? ***Please choose only your top 5 from the following:***

- Access to affordable health care
- Access to behavioral/mental health care
- Access to treatment for substance abuse
- Access to services for a family member with a developmental disability
- Health/wellness education
- Supportive programs for all age groups
- Good jobs/a healthy economy
- Strong educational system/institutions
- Strong social networks

DEMOGRAPHIC INFORMATION

51. Gender:

- Female
- Male

52. Age

- 18-29
- 30-39
- 40-49
- 50-59
- 60-69

70 or Older

53. Including yourself, how many people in your household?

Children (ages 0-15) _____

Adults (ages 16-60) _____

Adults (60 and over) _____

54. What is the highest level of school that you have finished?

Less than high school degree

High School diploma or GED

Some education after high school (including certificate or Associate's Degree programs)

Bachelor's degree

Graduate or professional degree

Thank you very much for taking the Bloomingdale Township Community Health Needs Assessment Survey. Your responses will help Bloomingdale Township better understand and meet the community's health needs.

