

Date and Time of Interview Date: ____/____/____ Time Started: _____ AM/PM Time Ended: _____ AM/PM Location: _____	Interviewer Name: _____ Height: ____ feet ____ in or _____ cm Weight: _____ lbs or _____ kg A1c Result: _____ Date of A1c Result: ____/____/____ Source of A1c: 1) abstract medical record 2) self-report 3) A1cNOW test 4) other _____ After this date (Date of A1c Result: ____/____/____), did you go to the doctor's office to check your blood sugar? 1) Yes [please remember to contact the doctor's office to update the A1c result and date] 2) No 3) Don't remember/not sure
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Eating Behaviors

Now think about the foods you ate or drank during the past month, that is, the past 30 days, including meals and snacks. *Ask the participant use his/her fist as the equivalent of a cup.*

1. In the past 30 days, on average, how many cups of fruits do you eat each day? INTERVIEWER NOTE: INCLUDE FRESH, FROZEN OR CANNED FRUIT. DO NOT INCLUDE DRIED FRUITS. *Ask the participant use his/her fist as the equivalent of a cup.*

____ cups

- ☐ Don't Know
☐ Refused

2. In the past 30 days, on average, how many cups of vegetables do you eat each day? INTERVIEWER NOTE: DO NOT INCLUDE POTATO, SWEET POTATO. INCLUDE GREEN LEAFY VEGETABLES, TOMATOES, GREEN BEANS, CARROTS, CORN, CABBAGE, BEAN SPROUTS, COLLARD GREENS, AND BROCCOLI. INCLUDE RAW, COOKED, CANNED, OR FROZEN VEGETABLES. *Ask the participant use his/her fist as the equivalent of a cup.*

____ cups

- ☐ Don't Know
☐ Refused

3. In the past 30 days, on average, how many cups of refined grains (which includes white rice, regular noodles, regular bread, regular dumplings, regular bun) do you eat each day? *Ask the participant use his/her fist as the equivalent of a cup.*

____ cups

- ☐ Don't Know

☐ Refused

4. In the past 30 days, on average, how many cups of whole grains (which includes brown rice, millet, whole wheat, barley, whole wheat noodles, whole wheat bread, whole wheat-based dumplings or bun) do you eat each day? *Ask the participant use his/her fist as the equivalent of a cup.*

_____ cups

☐ Don't Know

☐ Refused

5. In the past 30 days, on average, how many cans of sugary drinks (e.g., regular or diet coke, fruit juice, bubble milk tea) do you drink each day? *Ask the participant think the size of coke can.*

_____ cups

☐ Don't Know

☐ Refused

6. In the past 30 days, on average, how many cups of potatoes do you eat each day? *Ask the participant use his/her fist as the equivalent of a cup.*

_____ cups

☐ Don't Know

☐ Refused

7. In general, how healthy is your overall diet?

☐ Excellent

☐ Very Good

☐ Good

☐ Fair

☐ Poor

8. How often did you read food nutrition label?

☐ Almost Never or Never

☐ Sometimes

☐ Often

☐ Almost always or Always

9. Who does most of the shopping and cooking of meals in your family?

☐ Myself

☐ My spouse

☐ My adult children

☐ Senior center delivers food to my home

☐ We do not cook and have take-out/dine out most of the time.

☐ Other, please specify_____

Physical Activity

1. During the **last 7 days**, on how many days did you do **large effort** physical activities like heavy lifting, digging, aerobics, or fast bicycling that make your heart rate and breathing much faster? Activities can take place at home, at work, in the gym or elsewhere but **think about only those physical activities that you do for at least 10 minutes at a time.**

_____ **days per week**

- ☐ No vigorous physical activities → **Skip to question 3**

1a. What large effort physical activities did you perform?

- ☐ Running or jogging
- ☐ Lifting weights or heavy loads
- ☐ Aerobics
- ☐ Aerobic dance or jump rope
- ☐ Other _____

2. How much time did you usually spend doing **these large effort** physical activities on one of those days? *[If participant answers that the length of time varies, ask them to think about a normal day or the last day they did these types of physical activities]*

_____ **minutes per day**

- ☐ Don't know/Not sure

Now think about activities which take **moderate** physical effort that you did in the **last 7 days**. **Moderate** physical activities make you breathe somewhat harder than normal, but not so much that you are out of breath. Activities can take place at home, at work, in the gym or elsewhere but **think about only those physical activities that you do for at least 10 minutes at a time.**

3. During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying shopping bags or laundry, bicycling at a regular pace, or doubles tennis? Do not include walking.

_____ **days per week**

- ☐ No moderate physical activities → **Skip to question 5**

3a. What moderate physical activities did you perform?

- ☐ Carrying shopping bags or laundry
- ☐ Gardening
- ☐ Stretching
- ☐ Tai chi
- ☐ Sit-ups
- ☐ Push-ups
- ☐ Raise milk bottles, water bottles, disinfectant bottles, laundry detergent bottles
- ☐ Other _____

4. How much time did you usually spend doing **moderate** physical activities on one of those days? *[If participant answers that the length of time varies, ask them to think about a normal day or the last day they did these types of physical activities]*
 _____ **minutes per day**

☐ Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

5. During the **last 7 days**, on how many days did you **walk for at least 10 minutes at a time**?

_____ **days per week**

☐ No walking ➔ **Skip to question 7**

6. How much time did you usually spend **walking** on one of those days?

_____ **minutes per day**

☐ Don't know/Not sure

The last question is about the time you spent **sitting** on weekdays during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

7. During the **last 7 days**, how much time did you spend **sitting** on a **week day**?
 _____ **minutes per day**

☐ Don't know/Not sure

8. During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles (such as lifting dumbbells, milk bottles, push-ups, sit-ups, squats, using elastic bands)?

☐ Never

_____ **times per week**

_____ **times per month**

☐ Don't know/Not sure

The Summary of Diabetes Self-Care Activities

The questions below ask you about your diabetes self-care activities during the past 7 days. If you were sick during the past 7 days, please think about the last 7 days that you were not sick.

Diet

1. How many of the last **SEVEN DAYS** have you followed a healthful eating plan?

0 1 2 3 4 5 6 7

2. On average, over the past month, how many DAYS PER WEEK have you followed your eating plan?

0 1 2 3 4 5 6 7

3. On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables?

0 1 2 3 4 5 6 7

4. On how many of the last SEVEN DAYS did you eat high fat foods such as red meat or full-fat dairy products?

0 1 2 3 4 5 6 7

Exercise

5. On how many of the last SEVEN DAYS did you participate in at least 30 minutes of physical activity? (Total minutes of continuous activity, including walking)

0 1 2 3 4 5 6 7

6. On how many of the last SEVEN DAYS did you participate in a specific exercise session (such as swimming, walking, biking) other than what you do around the house or as part of your work?

0 1 2 3 4 5 6 7

Blood Sugar Testing

7a. Has your doctor recommended you check your blood sugar at home?

____ NO (Go to Q9)

____ YES (If Yes, how often did your doctor recommend? _____ Times per day or week)

7. On how many of the last SEVEN DAYS did you test your blood sugar?

0 1 2 3 4 5 6 7 N/A

8. On how many of the last SEVEN DAYS did you test your blood sugar the number of times recommended by your health care provider?

0 1 2 3 4 5 6 7 N/A

Foot Care

9. On how many of the last SEVEN DAYS did you check your feet?

0 1 2 3 4 5 6 7 N/A

10. On how many of the last SEVEN DAYS did you inspect the inside of your shoes?

0 1 2 3 4 5 6 7 N/A

Medications

What medications has your doctor prescribed for your diabetes?

____ a) Oral diabetes medication

____ b) Insulin

____ c) Injectables that are not insulin

____ d) My doctor did not prescribe any diabetes medication for me.

11. On how many of the last SEVEN DAYS, did you take your recommended oral diabetes medication?

0 1 2 3 4 5 6 7 N/A

12. On how many of the last SEVEN DAYS, did you take your recommended number of diabetes pills?

0 1 2 3 4 5 6 7 N/A

13. On how many of the last SEVEN DAYS, did you take your recommended insulin injections?

0 1 2 3 4 5 6 7 N/A

Self-Efficacy for Diabetes

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

Not at all
confident

Totally
confident

1. How confident do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day?

1 2 3 4 5 6 7 8 9 10

2. How confident do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes?

1 2 3 4 5 6 7 8 9 10

3. How confident do you feel that you can choose the appropriate foods to eat when you are hungry (for example, snacks)?

1 2 3 4 5 6 7 8 9 10

4. How confident do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week?

1 2 3 4 5 6 7 8 9 10

5. How confident do you feel that you can do something to prevent your blood sugar from dropping when you exercise?

1 2 3 4 5 6 7 8 9 10

6. How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be?

1 2 3 4 5 6 7 8 9 10

7. How confident do you feel that you can judge when the changes in your illness mean you should visit the doctor?

1 2 3 4 5 6 7 8 9 10

8. How confident do you feel that you can control your diabetes so that it does not interfere with things you want to do?

1 2 3 4 5 6 7 8 9 10

Diabetes Knowledge

1. Have you ever taken a course or class in how to manage your diabetes in the United States?

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

2. About how often do you check your blood for glucose or sugar? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

[CHOOSE ONE; WRITE IN NUMBER OF TIMES]

_____ times per day	Never
_____ times per week	Don't know / Not sure
_____ times per month	Refused
_____ times per year	

3. About how often do you check your feet for sores or irritations? Include times when checked by a family member or friend, but do NOT include times when checked by a health professional.

[CHOOSE ONE; WRITE IN NUMBER OF TIMES]

_____ times per day	No feet
_____ times per week	Never
_____ times per month	Don't know / Not sure
_____ times per year	Refused

4. A test for "A1c" measures the average level of blood sugar over the past three months. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for "A1c"?

_____ [WRITE IN NUMBER OF TIMES]

None
Never heard of "A one C" test
Don't know / Not sure
Refused

5. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes?

_____ [WRITE IN NUMBER OF TIMES]

None
Don't know / Not sure

6. About how many times in the past 12 months has a health professional checked your feet for any sores or irritations?

_____ [WRITE IN NUMBER OF TIMES]

None
Don't know / Not sure

7. When was the last time you had an eye exam in which the pupils were dilated?

NOTES: PUPIL DILATION INVOLVES GETTING EYE DROPS TO MAKE YOUR PUPILS LARGER.

- ☐ Within the past month

- ☐ Within the past year
☐ Within the past 2 years
☐ 2 or more years ago
☐ Don't know/Not sure
☐ Never
☐ Refuse

8. Has a doctor ever told you that diabetes has affected your eyes or your kidney?

- ☐ Yes
☐ No
- Don't Know/Not Sure
 Refused

Beliefs in Diabetes Self-Management

How important is each of the following for controlling your diabetes?	Not important 1	2	3	4	Extremely important 5
1. Diabetic diet	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>
2. Exercise	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>
3. Self-monitoring blood glucose	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>
4. Medication	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>
5. Checking feet	1- <input type="checkbox"/>	2- <input type="checkbox"/>	3- <input type="checkbox"/>	4- <input type="checkbox"/>	5- <input type="checkbox"/>

Mental Health of Diabetes
Social Support

	Never 1	Rarely 2	Sometimes 3	Usually 4	Always 5
1. I have someone who will listen to me when I need to talk					
2. I have someone to confide in or talk to about myself or my problems					
3. I have someone who makes me feel appreciated					
4. I have someone to talk with when I have a bad day					

Mental Health

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
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1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				

Diabetes Distress

Living with Diabetes can sometimes be tough. There may be many problems and hassles concerning diabetes and they can vary greatly in severity. Problems may range from minor hassles to major life difficulties. Listed below are 17 potential problem areas that people with diabetes may experience. Consider the degree to which each of the 17 items may have distressed or bothered you DURING THE PAST MONTH.

	Not a problem	A slight problem	A moderate problem	Somewhat serious problem	A serious problem	A very serious problem
1. Feeling that diabetes is taking up too much of my mental and physical energy every day.						
2. Feeling that my doctor doesn't know enough about diabetes and diabetes care.						
3. Feeling angry, scared, and/or depressed when I think about living with diabetes.						
4. Feeling that my doctor doesn't give me clear enough directions on how to manage my diabetes.						
5. Feeling that I am not testing my blood sugars frequently enough.						
6. Feeling that I am often failing with my diabetes routine.						
7. Feeling that friends or						

family are not supportive enough of self-care efforts (e.g. planning activities that conflict with my schedule, encouraging me to eat the "wrong" foods).						
8. Feeling that diabetes controls my life.						
	Not a problem	A slight problem	A moderate problem	Somewhat serious problem	A serious problem	A very serious problem
9. Feeling that my doctor doesn't take my concerns seriously enough.						
10. Not feeling confident in my day-to-day ability to manage diabetes.						
11. Feeling that I will end up with serious long-term complications, no matter what I do.						
12. Feeling that I am not sticking closely enough to a good meal plan.						
13. Feeling that friends or family don't appreciate how difficult living with diabetes can be.						
14. Feeling overwhelmed by the demands of living with diabetes.						
15. Feeling that I don't have a doctor who I can see regularly enough about my diabetes.						
16. Not feeling motivated to keep up my diabetes self-management.						
17. Feeling that friends or family don't give me the emotional support that I would like.						

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General Health Information

1. How would you describe your general health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

2. On average, how many hours of sleep do you get each night? _____ Hours

3. On average, how many hours of sleep do you get during the daytime nap? _____ Hours

4. How would you rate your fatigue on average?

- 1. None
- 2. Mild
- 3. Moderate
- 4. Severe
- 5. Very severe

5. Smoking history: Have you smoked at least 100 cigarettes (5 packs) in your entire life?

- a. Yes
- b. No
- c. Don't know/Not sure
- d. I've never smoked cigarettes/Not applicable → GO TO Q10

5a. What was the last time you smoked a cigarette, even a puff? _____ (date)

6. Do you now smoke cigarettes every day, some days, or not at all?

- a. Every day
- b. Some days
- c. Not at all
- d. Don't know/Not sure

7. On the days that you smoke, how many cigarettes on average do you smoke per day?

_____ CIGARETTES PER DAY

8. In the past three months have you ever stopped smoking cigarettes for a day or more because you were trying to quit?

- a. Yes
- b. No
- c. Didn't smoke in the last 3 months

9. During the last 12 months, how often did you usually have any kind of drink containing alcohol? By a drink we mean half an ounce of absolute alcohol (e.g. a 12 ounce can or glass of beer or cooler, a 5 ounce glass of wine, or a drink containing 1 shot of liquor). Choose only one.

- a) Every day
- b) 5 to 6 times a week
- c) 3 to 4 times a week
- d) twice a week
- e) once a week
- f) 2 to 3 times a month
- g) once a month
- h) 3 to 11 times in the past year
- i) 1 or 2 times in the past year
- j) Not at all

Memory Test Questions

1. What is the year?

1 = Correct
0 = Error
88 = DK
99 = RF

2. What is the season of the year?

1 = Correct
0 = Error
88 = DK
99 = RF

3. What is the date?

1 = Correct
0 = Error
88 = DK
99 = RF

4. What is the day of the week?

1 = Correct
0 = Error
88 = DK
99 = RF

5. What is the month?

1 = Correct
0 = Error
88 = DK
99 = RF

6. Which state are you in? *[compare with information from phone screener]*

1 = Correct
0 = Error
88 = DK
99 = RF

7. What county are you in? *[compare with information from phone screener]*

1 = Correct

0 = Error

88 = DK

99 = RF

8. What city are you in? *[compare with information from phone screener]*

1 = Correct

0 = Error

88 = DK

99 = RF

9. What is the address of your place? *[compare with information from phone screener]*

1 = Correct

0 = Error

88 = DK

99 = RF

10. I am going to name 3 objects. After I have said them, I want you to repeat them. Remember what they are because I am going to ask you to name them again in a few minutes. The objects are: [SAY 1 WORD/SECOND]

Apple -- Newspapers -- Train. Now, please repeat the names for me.

1) [Apple]

1 = Correct

0 = Error

88 = DK

99 = RF

2) [Newspaper]

1 = Correct

0 = Error

88 = DK

99 = RF

3) [Train]

1 = Correct

0 = Error

88 = DK

99 = RF

11. Serial 7's. 1 point for each correct answer. Stop after 5 answers. (100 minus 7)

1) 93

1 = Correct

0 = Error

88 = DK

99 = RF

2) 86

1 = Correct

0 = Error

88 = DK

99 = RF

3) 79

1 = Correct

0 = Error

88 = DK

99 = RF

4) 72

1 = Correct

0 = Error

88 = DK

99 = RF

5) 65

1 = Correct

0 = Error

88 = DK

99 = RF

12. What are the three objects I asked you to remember?

1) [Apple]

1 = Correct

0 = Error

88 = DK

99 = RF

2) [Newspaper]

1 = Correct

0 = Error

88 = DK

99 = RF

3) [Train]

1 = Correct

0 = Error

88 = DK

99 = RF

13. Please identify the object you are speaking into right now? [my cell phone]

1 = Correct

0 = Error

88 = DK

99 = RF

14. I would like you to repeat a phrase after me. The phrase is: 'No if's, and's or but's.'" [Allow only one trial]

1 = Correct

0 = Error

88 = DK

99 = RF

15. Please say hello, tap the mouthpiece of the telephone three times, and say I am back.

1) [please say hello]

1 = Correct
0 = Error
88 = DK
99 = RF

2) [tap the mouthpiece of the telephone three times]

1 = Correct
0 = Error
88 = DK
99 = RF

3) [say I am back]

1 = Correct
0 = Error
88 = DK
99 = RF

16. Please tell me your cell phone number. [compare with information from phone screener]

1 = Correct
0 = Error
88 = DK
99 = RF

COVID-19 Related Questions

COVID Information

1. Did you ever get tested for COVID-19? Yes____; No____
If yes, what was the test result? Positive____; Negative____; DK/not sure____; Refused____
If positive, did it require hospitalization? Yes____; No____
2. Do you know any one (family or friend) passed away from COVID-19 or related complications?
Yes____; No____
3. Have you received the COVID-19 vaccine?
____Yes, I have received 2 doses.
____Yes, I have received one dose.
____No, please follow up with 3A

3A. If COVID-19 vaccine is available to you, are you planning to take the vaccine?
Yes____;
No____, if No, why?____
 - 1) I'm afraid to go to the doctor's office, afraid to catch COVID-19
 - 2) Worried about the safety of vaccines (include not trusting the government)
 - 3) I have infected the virus, I don't think I need to be vaccinated
 - 4) I don't think I will be infected (It's just a flu, God has his own arrangements)
 - 5) Worried about the side effects of the vaccine
 - 6) I have allergic reaction
 - 7) Religious reasons

8) Other_____

Health Care Services

4. Has your health care been interrupted because of COVID-19?
- ☐ Yes, I didn't go to see my doctor (doctor's office closed, appointment was cancelled, I was afraid to go)
 - ☐ Yes, I was able to see my doctor, but I experienced delays in obtaining an appointment
 - ☐ Yes, I was able to see my doctor through telemedicine
 - ☐ No interruption
5. Did you lose your health insurance due to COVID-19?
- Yes
 - No

Financial

6. Has your Household income changed significantly since the beginning of COVID-19? (please EXCLUDE a stimulus payment from the federal government if you have received one)
- a. 1 ☐ Yes, my household income is more
 - b. 2 ☐ Yes, my household income is less
 - c. 3 ☐ No, my household income is about the same

Employment Status

7. How did COVID-19 affect your employment status? (check all that apply)
- a. Furlough (Temporarily laid off, leave of absence)
 - b. Still employed but with decreased hours
 - c. Still employed but with increased hours
 - d. Still employed but have moved to online/remote work
 - e. Laid off
 - f. No change
 - g. Unknown at this time
 - h. Retired
 - i. Other (please specify)

Diet

8. Since the beginning of COVID-19, have you ever eaten less than you felt you should because there wasn't enough money to buy food?
- 1 ☐ Yes
 - 2 ☐ No
 - ☐ Don't know
 - ☐ Refused
9. Since the beginning of COVID-19, have you had any difficulty obtaining the food you need?
- ☐ Yes
 - ☐ No

10. Compared to before the COVID-19 outbreak, do you think there are changes in your fresh fruits and vegetables intake?

- ☐ Yes, I feel that I am eating fewer fresh fruits and vegetables
- ☐ Yes, I feel that I am eating more fresh fruits and vegetables
- ☐ No, I am eating the same

Physical Activity

11. Compared to before the COVID-19 outbreak, do you think there are changes in your physical activities?

- ☐ Yes, I feel that I am exercising less
- ☐ Yes, I feel that I am exercising more
- ☐ No, it's the same

COVID-19 Discrimination

12. Since the beginning of COVID-19, have you or someone you know experienced discrimination because of being Chinese?

- ☐ Yes
- ☐ No

13. Were you worried that you would experience COVID-19 related discrimination (e.g. being bullied on public transportation, verbal harassment, lost your job, etc.)?

- ☐ Yes
- ☐ No

Stress

14. Compared to before the COVID-19 outbreak, do you think there are changes in your stress level?

- ☐ Yes, I feel that my stress level is lower
- ☐ Yes, I feel that my stress level is higher
- ☐ No change

15. Compared to before the COVID-19 outbreak, how isolated do you feel from others now?

- ☐ Much less isolated now than before the pandemic
- ☐ About the same
- ☐ Much more isolated now than before the pandemic
- ☐ 99. Refused/missing

Satisfaction Survey						
To what extent do you agree with the following statements?	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Not Applicable
1. It was easy to receive and view the WeChat diabetes videos from the research team.						
2. I found this program to be helpful for providing me more information about healthy diet						
3. I found this program to be helpful for providing me more information about						

physical activity						
4. I found this program to be helpful at motivating me to take my diabetes medication as prescribed						
5. I found this program to be helpful at motivating me to check my blood sugar as recommended						
6. I found this program to be helpful at increasing my confidence to manage my diabetes						
To what extent do you agree with the following statements?	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Not Applicable
7. I would be willing to join similar programs in the future to help me manage my diabetes.						
8. I would recommend this program to my friends/family that have diabetes.						
9. I prefer to receive diabetes education via WeChat than scheduling appointment and going to doctor's office						

10. Overall, how satisfied were you with our program?

0	1	2	3	4	5	6	7	8	9	10
Not at all	A Little Satisfied		Neutral			Very Satisfied		Totally Satisfied		

11. What factors prevented you from watching the videos? (Check all that apply)

- ☐ Cannot open the videos (due to internet/other technology issues)
☐ Lack of interest
☐ Forgetfulness
☐ Too busy (with work or other family obligations)
☐ Holiday/Vocation interrupts my routine
☐ Other _____