

ADA INCLUDE Participant ID_____ Date_____ Location_____ Interviewer Initials_____

Thank you again for agreeing to participate in our study. The survey will take approximately 30-45 minutes to complete. The information you provide in the survey is completely confidential. If at any time, you are confused about a question, please let me know.

Contact Information

Please provide the following information for our records (this page will be removed from the questionnaire and kept locked in a separate file):

Your Name: _____

Cell Phone Number: _____

<p>Date and Time of Interview</p> <p>Date: ____/____/____</p> <p>Time Started: _____AM/PM</p> <p>Time Ended: _____AM/PM</p> <p>Location: _____</p>	<p>Interviewer Name: _____</p> <p>Height: ____ feet ____ in or _____ cm</p> <p>Weight: _____ lbs or _____ kg</p>
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For baseline use only:

Background Information	
This series of questions is a standard collection of background information that will be used for research purposes only. As with everything else in the study, all of the information you provide will be kept confidential.	
1. What is your gender?	<input type="checkbox"/> Female <input type="checkbox"/> Male
2. What is our date of birth? (mm/dd/yyyy)	____/____/19____ mm dd year
3. What country were you born in?	<input type="checkbox"/> China <input type="checkbox"/> Hong Kong <input type="checkbox"/> Taiwan <input type="checkbox"/> the United States <input type="checkbox"/> Other, please specify _____
4. How many years have you lived in the United States?	____ [write in year]
5. What is your marital status?	<input type="checkbox"/> Currently married or living as married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced or Separated <input type="checkbox"/> Never married or Single <input type="checkbox"/> Other (please specify) _____
6. What is your employment status?	<input type="checkbox"/> Employed full-time for wages <input type="checkbox"/> Part-time (one job) <input type="checkbox"/> Part-time (multiple jobs) <input type="checkbox"/> Self-employed <input type="checkbox"/> Not employed, not working <input type="checkbox"/> Other _____
7. What is your primary occupation?	____ [write in]
8. How many hours a week do you work on average?	____ [write in number of hours]
9. How well is your English?	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well

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		<input type="checkbox"/> Not at all	
10. What is the highest grade or year of school you completed?		a. Never attended school or only attended kindergarten b. Grades 1 through 8 (Elementary) c. Grades 9 through 11 (Some high school) d. Grade 12 or GED (High school graduate) e. College 1 year to 3 years (Some college or technical school) f. College 4 years or more (College graduate or more) 98. Don't know/Not sure 99. Decline to state	
Skip Question 10a if the answer is not 5 or 6.			
10a. Did you go to college in the United States?		1. Yes 2. No 3. Don't know/Not sure 4. Refused	
We are trying to understand how your income affects your ability to take care of your diabetes.			
11. What is your TOTAL household income from all sources per year?		1. <\$25,000 2. \$25,000-\$55,000 3. >\$55,000 98. Don't know/Not sure 99. Decline to state	
Skip Question 11a if the answer is not 98,			
11a. What is your weekly or monthly household income from all sources?		Write-in: _____ (Choose Weekly or Monthly) 98. Don't know/Not sure 99. Decline to state	
12. Does your current household income meet your basic needs (including food, housing, utilities, medications, and other health care)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused <input type="checkbox"/> SKIPPED	
13. What kind of health insurance do you have? Please check only one.		a) Medicaid ("White Card") [READ IF NEEDED: Medicaid is a health insurance program for persons whose income and resources cannot cover the costs of health care.] b) Medicare ("Blue and Red Card") [READ IF NEEDED: Medicare is a health insurance program for people 65 and older or persons with disabilities.] c) Private insurance	

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		d) Other type of public/government insurance (Family Health Plus, Child Health Plus) e) Work or company insurance f) No health insurance g) Other _____	

For baseline, 3-month, and 6-month follow-up:

Dietary Intake – Starting the Conversation Diet Scale			
Over the past few months:			
1. How many times a week did you eat fast food meals or snacks?	Less than 1 time	1-3 times	4 or more times
2. How many servings of fruit did you eat each day?	5 or more	3-4	2 or less
3. How many servings of vegetables did you eat each day?	5 or more	3-4	2 or less
4. How many regular sodas or bubble milk tea did you drink each day?	Less than 1	1-2	3 or more
5. How many times a week did you eat chicken, fish, tofu, or beans (like soybeans, edamame, black beans, mung beans, red beans)?	3 or more times	1-2 times	Less than 1 time
6. How many times a week did you eat regular snack chips or crackers (not low-fat)?	1 time or less	2-3 times	4 or more times
7. How many times a week did you eat desserts and other sweets (not the low-fat kind)?	1 time or less	2-3 times	4 or more times
8. How much margarine, butter or meat fat do you use to season vegetables or put on bread, potatoes, or corn?	Very little	Some	A lot
1 serving of fruit could be: <ul style="list-style-type: none"> • 1 medium apple • 1 small banana • 1 medium orange • 4 large strawberries • 1 medium pear • 2 large plums • 32 seedless grapes • 0.5 cups dried fruit • 1 inch-thick (2.5cm) wedge of watermelon 	1 serving of vegetable could be: <ul style="list-style-type: none"> • 3 broccoli spears • 1 cup cooked leafy greens • 2 cups lettuce or raw greens • 12 baby carrots • 1 medium potato • 1 large sweet potato • 1 large ear of corn • 1 large raw tomato • 2 large celery sticks • 1 cup of cooked beans 		
9. In general, how healthy is your overall diet?	<input type="checkbox"/> Excellent		

	<input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
10. How often did you read food nutrition label?	<input type="checkbox"/> Almost Never or Never → Go to Q11 <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Almost always or Always
10a. How well do you understand the information on a food nutrition label?	<input type="checkbox"/> Very well <input type="checkbox"/> Well <input type="checkbox"/> Not well <input type="checkbox"/> Not at all
11. Who does most of the shopping and cooking of meals in your family?	<input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My adult children <input type="checkbox"/> Senior center delivers food to my home <input type="checkbox"/> We do not cook and have take-out/dine out most of the time <input type="checkbox"/> Other, please specify _____

Physical Activity - International Physical Activity Questionnaire (IPAQ)

<p>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.</p>	<p>_____ days per week</p> <p><input type="checkbox"/> No vigorous physical activities → Skip to question 3</p> <p>1a. What large effort physical activities did you perform?</p> <p><input type="checkbox"/> Running or jogging</p> <p><input type="checkbox"/> Lifting weights or heavy loads</p> <p><input type="checkbox"/> Aerobics</p> <p><input type="checkbox"/> Aerobic dance or jump rope</p> <p><input type="checkbox"/> Other _____</p>
<p>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]</p>	<p>_____ minutes per day</p> <p><input type="checkbox"/> Don't know/Not sure</p>
<p>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.</p>	
<p>3. During the last 7 days, on how many days did you do moderate physical</p>	<p>_____ days per week</p>

Now I'm going to read you several statements that people have made about their **food situation**. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months.

- | | |
|---|---|
| 1. The first statement is: ‘(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more.’ Was that often | 1. Often true
2. Sometimes true
3. Never true |
|---|---|

ADA INCLUDE Participant ID _____	Date _____	Location _____	Interviewer Initials _____
true, sometimes true, or never true for (you/your household) in the last 12 months?			
2. 'The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more.' Was that often, sometimes, or never true for (you/your household) in the last 12 months?		1. Often true 2. Sometimes true 3. Never true	
3. '(I/we) couldn't afford to eat balanced meals.' Was that often, sometimes, or never true for (you/your household) in the last 12 months?		1. Often true 2. Sometimes true 3. Never true	
4. In the last 12 months, since last [name of current month], did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?		1. Yes 2. No	
5. If 'yes' to previous item: How often did this happen – almost every month, some months but not every month, or in only 1 or 2 months?		1. Almost every month 2. Some months but not every month 3. Only 1 or 2 months	
6. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?		1. Yes 2. No	
7. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?		1. Yes 2. No	
8. In the last 12 months, did you lose weight because there wasn't enough money for food?		1. Yes 2. No	
9. In the last 12 months, did (you/you or other adults in your household) ever not eat for a whole day because there wasn't enough money for food?		1. Yes 2. No	
10. If 'yes' to previous item: How often did this happen – almost every month, some months but not every month, or in only 1 or 2 months?		1. Almost every month 2. Some months but not every month 3. Only 1 or 2 months	
Now I'm going to read you several statements that people have made about <u>the food situation of their children</u> . For these statements, please tell me whether the statement was often true, sometimes true, or never true in the last 12 months for (your child/children living in the household who are under 18 years old).			
11. '(I/we) relied on only a few kinds of low-cost food to feed (my/our) (child/the children) because (I was/we were) running out of money to buy food.' Was that often, sometimes, or never true for (you/your household) in the last 12 months?		1. Often true 2. Sometimes true 3. Never true	
12. '(I/We) couldn't feed (my/our) (child/the children) a balanced meal, because (I/we) couldn't afford that.' Was that often, sometimes, or never true for (you/your household) in the last 12 months?		1. Often true 2. Sometimes true 3. Never true	
13. '(My/Our child was/The children were) not eating enough because (I/we) just couldn't afford enough food.' Was that often, sometimes, or never true for (you/your household) in the last 12 months?		1. Often true 2. Sometimes true 3. Never true	
14. In the last 12 months, since [current month] of last year, did you ever cut the size of (your child's/any of the children's) meals because there wasn't enough money for food?		1. Yes 2. No	
15. In the last 12 months, did ([child's name]/any of the children) ever skip meals because there wasn't enough money for food?		1. Yes 2. No	
16. If 'yes' to previous item: How often did this happen – almost every month, some months but not every month, or in only 1 or 2 months?		1. Almost every month 2. Some months but not every month 3. Only 1 or 2 months	

ADA INCLUDE Participant ID	Date	Location	Interviewer Initials
17. In the last 12 months, (was your child/were the children) ever hungry but you just couldn't afford more food?	1. Yes 2. No		
18. In the last 12 months, did (your child/any of the children) ever not eat for a whole day because there wasn't enough money for food?	1. Yes 2. No		

Self-Efficacy - Weight Efficacy Lifestyle Questionnaire (WEL)										
We would like to know how confident you are in resisting eating in various situations. 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 confident					Very confident				
	0	1	2	3	4	5	6	7	8	9
1. I can resist eating when I am anxious (nervous).	0	1	2	3	4	5	6	7	8	9
2. I can control my eating on the weekends.	0	1	2	3	4	5	6	7	8	9
3. I can resist eating even when I have to say "no" to others.	0	1	2	3	4	5	6	7	8	9
4. I can resist eating when I feel physically run down.	0	1	2	3	4	5	6	7	8	9
5. I can resist eating when I am watching TV.	0	1	2	3	4	5	6	7	8	9
6. I can resist eating when I am depressed (or down).	0	1	2	3	4	5	6	7	8	9
7. I can resist eating when there are many different kinds of food available.	0	1	2	3	4	5	6	7	8	9
8. I can resist eating even when I feel it's impolite to refuse a second helping.	0	1	2	3	4	5	6	7	8	9
9. I can resist eating even when I have a headache.	0	1	2	3	4	5	6	7	8	9
10. I can resist eating when I am reading.	0	1	2	3	4	5	6	7	8	9
11. I can resist eating when I am angry (or irritable).	0	1	2	3	4	5	6	7	8	9
12. I can resist eating even when I am at a party.	0	1	2	3	4	5	6	7	8	9
13. I can resist eating even when others are pressuring me to eat.	0	1	2	3	4	5	6	7	8	9
14. I can resist eating when I am in pain.	0	1	2	3	4	5	6	7	8	9
15. I can resist eating just before going to bed.	0	1	2	3	4	5	6	7	8	9
16. I can resist eating when I have experienced failure.	0	1	2	3	4	5	6	7	8	9
17. I can resist eating even when high-calorie foods are available.	0	1	2	3	4	5	6	7	8	9
18. I can resist eating even when I think others will be upset if I don't eat.	0	1	2	3	4	5	6	7	8	9
19. I can resist eating when I feel uncomfortable.	0	1	2	3	4	5	6	7	8	9
20. I can resist eating when I am happy.	0	1	2	3	4	5	6	7	8	9

Social Determinants of Health-NYU Brooklyn SDOH screener		
	Yes	No
1. Would you like to take classes to help you learn English, read better, or get your high school degree?		
2. Do you need help getting things for your child (like diapers, car seats, cribs, or strollers)?		

3. Do you need help finding someone to watch your child when you are doing other things, like working or taking a class?		
4. Do you have any problems with your home – like mold, broken walls, peeling paint, or pests (like insects or rats)?		
5. Do you worry that your family will not have a place to live because you can't pay rent, because your electricity will be turned off, or because you'll be evicted?		
6. Do you feel unsafe at home due to domestic violence?		
7. Do you need help signing up for programs that can help your family find health insurance or pay less taxes?		
8. Do you need help from a lawyer for problems like immigration status, divorce, or custody issues?		
9. Are you worried about your child's behavior (like tantrums or hitting)?		
10. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?		
11. Do you or someone in your household need help cutting down on smoking, drinking, or drug use ?		

Access to Health Services – NHIS Utilization Questionnaire (Item 1-5, 9-10)	
1. About how long has it been since you last saw a doctor or other health care professional about your health?	0. Never* 1. Within the past year (anytime less than 12 months ago) 2. Within the last 2 years (1 year but less than 2 years ago) 3. Within the last 3 years (2 years but less than 3 years ago) 4. Within the last 5 years (3 years but less than 5 years ago) 5. Within the last 10 years (5 years but less than 10 years ago) 6. 10 years ago or more 7. Refused* 9. Don't know*
*Go to question 4 if answer is “Never”, “Refused”, or “Don't know”.	
2. Was this a wellness visit, physical, or general-purpose check-up?	1. Yes* 2. No 7. Refused 9. Don't know
*Go to question 4 if answer is “Yes”.	
3. About how long has it been since you last saw a doctor or other health professional for a wellness visit, physical, or general-purpose check-up?	0. Never 1. Within the past year (anytime less than 12 months ago) 2. Within the last 2 years (1 year but less than 2 years ago) 3. Within the last 3 years (2 years but less than 3 years ago) 4. Within the last 5 years (3 years but less than 5 years ago) 5. Within the last 10 years (5 years but less than 10 years ago) 6. 10 years ago or more 7. Refused 9. Don't know
4. Is there a place that you USUALLY go to if you are sick and need health care?	1. Yes 2. There is NO place* 3. There is MORE THAN ONE place 7. Refused 9. Don't know
*Go to question 6 if answer is “There is NO place”.	

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<p>5. What kind of place is it/do you go to most often - a doctor's office or health center; an urgent care center, a clinic in a drug store or grocery store; a hospital emergency room; a VA Medical Center or VA outpatient clinic; or some other place?</p> <p><i>Read if necessary: A doctor's office or health center is a place where you see the same doctor or the same group of doctors every visit, where you usually need to make an appointment ahead of time, and where your medical records are on file.</i></p> <p><i>Read if necessary: Urgent care centers and clinics in a drug store or grocery store are places where you do not need to make an appointment ahead of time, and do not usually see the same health care provider at each visit.</i></p>	<p>1. A doctor's office or health center 2. Walk-in clinic, urgent care center, or retail clinic in a pharmacy or grocery store 3. Emergency room 4. A VA Medical Center or VA outpatient clinic 5. Some other place 6. Does not go to one place most often 7. Refused 9. Don't know</p>		
6. During the past 12 months, have you DELAYED getting medical care because of the cost?	<p>1. Yes 2. No 7. Refused 9. Don't know</p>		
7. During the past 12 months, was there any time when you needed medical care, but DID NOT GET IT because of the cost?	<p>1. Yes 2. No 7. Refused 9. Don't know</p>		

Perceived Stress Scale

The questions in this scale ask you about your feelings and thoughts during the **last month**. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. In the last month, how often have you felt nervous and "stressed"?	0	1	2	3	4
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. In the last month, how often have you felt that things were going your way?	0	1	2	3	4
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. In the last month, how often have you been able to control irritations in your life?	0	1	2	3	4

ADA INCLUDE Participant ID _____	Date _____	Location _____	Interviewer Initials _____		
8. In the last month, how often have you felt that you were on top of things?	0	1	2	3	4
9. In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

PHQ-2

How often have you been bothered by the following over **the past 2 weeks**?

	Not at all	Several days	More than half days	Nearly everyday
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3

General Health Information

1. How would you describe your general health?	<input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> 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. Have you ever been told by your doctor that you have or have had any of the following conditions?																					
<table border="0"> <tr> <td><input type="checkbox"/>pre-diabetes</td> <td><input type="checkbox"/>high cholesterol</td> <td><input type="checkbox"/>cancer</td> <td><input type="checkbox"/>asthma</td> </tr> <tr> <td><input type="checkbox"/>diabetes</td> <td><input type="checkbox"/>Stomach disease or ulcer</td> <td><input type="checkbox"/>depression/anxiety</td> <td><input type="checkbox"/>obesity</td> </tr> <tr> <td><input type="checkbox"/>heart disease</td> <td><input type="checkbox"/>kidney disease</td> <td><input type="checkbox"/>arthritis</td> <td><input type="checkbox"/>insomnia</td> </tr> <tr> <td><input type="checkbox"/>high blood pressure</td> <td><input type="checkbox"/>liver disease</td> <td><input type="checkbox"/>back pain</td> <td><input type="checkbox"/>hepatitis (A, B, or C)</td> </tr> <tr> <td><input type="checkbox"/>lung disease</td> <td><input type="checkbox"/>stroke</td> <td><input type="checkbox"/>memory loss, mild cognitive impairment, or Alzheimer's disease</td> <td><input type="checkbox"/>other, please specify_____</td> </tr> </table>		<input type="checkbox"/> pre-diabetes	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> cancer	<input type="checkbox"/> asthma	<input type="checkbox"/> diabetes	<input type="checkbox"/> Stomach disease or ulcer	<input type="checkbox"/> depression/anxiety	<input type="checkbox"/> obesity	<input type="checkbox"/> heart disease	<input type="checkbox"/> kidney disease	<input type="checkbox"/> arthritis	<input type="checkbox"/> insomnia	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> liver disease	<input type="checkbox"/> back pain	<input type="checkbox"/> hepatitis (A, B, or C)	<input type="checkbox"/> lung disease	<input type="checkbox"/> stroke	<input type="checkbox"/> memory loss, mild cognitive impairment, or Alzheimer's disease	<input type="checkbox"/> other, please specify_____
<input type="checkbox"/> pre-diabetes	<input type="checkbox"/> high cholesterol	<input type="checkbox"/> cancer	<input type="checkbox"/> asthma																		
<input type="checkbox"/> diabetes	<input type="checkbox"/> Stomach disease or ulcer	<input type="checkbox"/> depression/anxiety	<input type="checkbox"/> obesity																		
<input type="checkbox"/> heart disease	<input type="checkbox"/> kidney disease	<input type="checkbox"/> arthritis	<input type="checkbox"/> insomnia																		
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> liver disease	<input type="checkbox"/> back pain	<input type="checkbox"/> hepatitis (A, B, or C)																		
<input type="checkbox"/> lung disease	<input type="checkbox"/> stroke	<input type="checkbox"/> memory loss, mild cognitive impairment, or Alzheimer's disease	<input type="checkbox"/> other, please specify_____																		
6. 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																				
6a. What was the last time you smoked a cigarette, even a puff?	_____ (date)																				
7. 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
8. On the days that you smoke, how many cigarettes on average do you smoke per day?	_____ cigarettes per day
9. 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
10. 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

Health Literacy - BRIEF Health Literacy Screening Tool					
Please circle the answer that best represents your response.					
	Always	Often	Sometimes	Occasionally	Never
1. How often do you have someone help you read hospital materials?	1	2	3	4	5
2. How often do you have problems learning about your medical condition because of difficulty understanding written information?	1	2	3	4	5
3. How often do you have a problem understanding what is told to you about your medical condition?	1	2	3	4	5
	Not at all	A little bit	Somewhat	Quite a bit	Extremely
4. How confident are you filling out medical forms by yourself?	1	2	3	4	5

Digital literacy – the eHealth Literacy Scale (eHEALS)					
I would like to ask you for your opinion and about your experience using the Internet for health information. For each statement, tell me which response best reflects your opinion and experience right now.					
	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. I know what health resources are available on the Internet	1	2	3	4	5
2. I know where to find helpful health resources on the Internet	1	2	3	4	5
3. I know how to find helpful health resources on the Internet	1	2	3	4	5
4. I know how to use the Internet to answer my questions about health	1	2	3	4	5
5. I know how to use the health information I find on the Internet to help me	1	2	3	4	5
6. I have the skills I need to evaluate the health resources I find on the Internet	1	2	3	4	5

ADA INCLUDE Participant ID _____ Date _____ Location _____ Interviewer Initials _____					
7. I can tell high quality health resources from low quality health resources on the Internet	1	2	3	4	5
8. I feel confident in using information from the Internet to make health decisions	1	2	3	4	5

Social Support – NIH Toolbox Social Relationship – Emotional Support

Please read each statement and then decide how much each applies to you in the past month. In the past month, please rate how often.....

	Never	Rarely	Sometimes	Usually	Always
1. I have someone who understands my problems					
2. I have someone who will listen to me when I need to talk					
3. I feel there are people I can talk to if I am upset					
4. I have someone to talk with when I have a bad day					
5. I have someone I trust to talk with about my problems					
6. I have someone I trust to talk with about my feelings					
7. I can get helpful advice from others when dealing with a problem					
8. I have someone to turn to for suggestions about how to deal with a problem					

Acculturation – Modified based on the Short Acculturation Scale for Hispanics PINE

The follow question is asking you about your acculturation level. Acculturation is the process of sharing and learning the cultural traits or social patterns of another group. Please select one option that is true for you.

	Only Chinese	More Chinese than English	Both equally	More English than Chinese	Only English
1. In general, what language(s) do you read and speak?					
2. What was the language (s) you used as a child?					
3. What language (s) do you usually speak at home?					
4. In which language (s) do you usually think?					
5. What language (s) do you usually speak with your friends?					
6. In what language (s) are the T.V. programs you usually watch?					
7. In what language (s) are the internet short videos (e.g., WeChat, tiktok) you usually listen to?					
8. In general, in what language (s) are the movies and T.V. you prefer to watch and listen to?					
	All Chinese	More Chinese than Americans	About half and half	More Americans than Chinese	All Americans
9. Your close friends are?					
10. You prefer going to social gatherings/parties at which the people are?					
11. The persons you visit or who visit you are?					

ADA INCLUDE Participant ID	Date	Location	Interviewer Initials
12. If you could choose your children's friends, you would want them to be?			

The Brief Illness Perception Questionnaire – Prediabetes version												
For the following questions, please circle the number that best corresponds to your views:												
1. How much would have relatively high blood sugar affect your life if you had it?												
No affect at all	0	1	2	3	4	5	6	7	8	9	10	Severely affects my life
2. How long do you think diabetes will last?												
A very short time	0	1	2	3	4	5	6	7	8	9	10	Forever
3. How much control do you feel you have over diabetes prevention?												
Absolutely no control	0	1	2	3	4	5	6	7	8	9	10	Extreme amount of control
4. In your opinion, how much help can professional treatment provide to prevent diabetes?												
Not at all	0	1	2	3	4	5	6	7	8	9	10	Extremely helpful
5. How many symptoms are related to diabetes?												
No symptoms at all	0	1	2	3	4	5	6	7	8	9	10	Many severe symptoms
6. How concerned are you about diabetes?												
Not at all concerned	0	1	2	3	4	5	6	7	8	9	10	Extremely concerned
7. How well do you feel you understand diabetes?												
Don't understand at all	0	1	2	3	4	5	6	7	8	9	10	Understand very clearly
8. How emotionally affected do you feel by the possibility of developing diabetes? (e.g., will it make you angry, scared, upset or depressed?)												
Not at all affected emotionally	0	1	2	3	4	5	6	7	8	9	10	Extremely affected emotionally
9. Please list in rank-order the three most important factors that you believe cause diabetes.												
The most important causes for diabetes:												
1. _____												
2. _____												
3. _____												

Satisfaction Survey (for the intervention group only)						
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						

ADA INCLUDE Participant ID	Date	Location			Interviewer Initials	
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						