

Evaluation of USDA Exercise Program

ID _____

Date _____

Please check the box that best describes your frequency during the past week.

<i>During the past week, on how many of the last seven days did you...</i>	None	1	2	3	4	5	6	Every day
1. Exercise more than 20 minutes?								
2. Use the exercise video?								
3. Use the resistance bands?								
4. Use the pedometer?								

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Did you get your family or friends to join you in becoming more active? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did you find the program useful in getting you started and/or motivated to exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Would you recommend others take part in this program? | <input type="checkbox"/> | <input type="checkbox"/> |

At this time, which of the barriers are preventing you from exercising as you would like?

Barrier	Yes	No	Not Sure
1. I don't have the time to exercise			
2. I am too tired to exercise			
3. I don't have anyone to exercise with me			
4. My muscles or joints hurt when I exercise			
5. A medical problem makes it hard			
6. Exercise is too boring			
7. I need a safe place to exercise			
8. I am too old or too overweight to exercise			
9. I don't see results when I exercise			
10. I am worried about low blood sugar			
11. Other:			

Please tell us...

What you liked most about the exercise class? _____

What you would change about the exercise class? _____

What you thought about the presenter's performance? _____

Please list any additional comments.

<i>Comments about the...</i>	1st exercise class	2nd exercise class
Video	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Stretch-bands/ Pedometers	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
Family or Friends	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____