



650 Townbank Rd.; STE 203; N. Cape May, NJ 08204 609 884-9800

Name: _____ Date: _____

Home Living Environment Questionnaire:

1. How many floors / levels are in your home (include basement)?

1 story 2 story 3 story other: _____

2. Do you have a ramp leading into your home? Yes No

3. How many steps leading into your home in...

a. ..front of your home? _____ Steps; Handrail on R L No Handrail

b. ..back of your home? _____ Steps; Handrail on R L No Handrail

c. ..side of your home? _____ Steps; Handrail on R L No Handrail

4. How many steps lead from the 1st floor to the 2nd floor? _____ Steps; If there is a handrail which side is the handrail on while going up the steps? R L Both sides; There is no handrail. If there is no handrail, what is there in place of it? Wall Nothing

Other: _____

How many steps lead from the 2nd floor to the 3rd floor? _____ Steps; If there is a handrail which side is the handrail on while going up the steps? R L Both sides; There is no handrail. If there is no handrail, what is there in place of it? Wall Nothing Other: _____

5. Is your home cluttered or present with a lot of obstacles or things you can trip over? Yes No. If Yes, please describe (e.g., loose rugs, toys laying around, pets, books, other): _____

6. Check off the following items that you have in your home

- | | | |
|--|---|---|
| <input type="checkbox"/> Throw rugs | <input type="checkbox"/> Bright lighting | <input type="checkbox"/> Sunken room (step down into) |
| <input type="checkbox"/> Bath chair or bench | <input type="checkbox"/> Non-skid bath mats | <input type="checkbox"/> Bathtub |
| <input type="checkbox"/> Shower stall | <input type="checkbox"/> Hand held showerhead | <input type="checkbox"/> Nightlights |
| <input type="checkbox"/> Raised toilet seat | <input type="checkbox"/> Slick/slippery floors | <input type="checkbox"/> Uneven ground outside |
| <input type="checkbox"/> Electric cords on floor | <input type="checkbox"/> Hills around yard/grounds | <input type="checkbox"/> Grab Bars in Tub |
| <input type="checkbox"/> Grab bars in Shower | <input type="checkbox"/> Grab bars in bathroom - Where? _____ | |
| <input type="checkbox"/> Other: _____ | | |

7. Are all lights working in your home? Yes No I don't know

8. I live Alone I live with family: Please describe - (e.g. husband/wife, son, daughter, friend(s), caregiver, pet(s), other): _____

9. Do family, friends or a Caregiver help you with anything and if so, how? _____

10. Are you Highly Active Moderately Active Not Very Active Sedentary (*couch potato*)

11. What activities are you involved with and do you feel safe participating in them? _____

12. Shoes:

- a. How old are your shoes? _____
- b. Do they feel safe to walk in? Yes No; _____
- c. Do they slip off your feet by accident at any time? Yes No _____
- d. Do the soles or any part of the shoe look worn down? Yes No _____
- e. Do they sit below your ankle or above your ankle? Above Below _____
- f. Are they comfortable? Yes No _____
- g. Do you wear an shoe insert or orthotic? Yes No; Describe: _____

13. Do you use an assistive device to walk and/or get around? Yes No If your answer is 'Yes', what do you use and where do you use it? _____

14. Do you use a wheelchair or a scooter? Yes No If your answer is 'Yes' what kind of wheelchair and/or scooter and where do you use it? _____

15. Do you furniture walk (use furniture in the home or outside the home to walk or get around)? Yes No. Describe: _____

16. Do you wear a Brace and/or a prosthesis? Yes No If your answer is 'Yes' what part of your body do you wear a brace or prosthesis? Is it or are they comfortable to wear and are they useful?

17. Anything else to share that might affect your sense of security, safety and/or sense of balance?

