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

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

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