



**Initial Assessment -
General**

1. Date

2. ID number:

3. Could not do assessment

- Received notification participant is deceased
- Participant moved
- Phone disconnected
- Deceased
- Other (please specify)

4. Would you like to stay in your home as you age?

- Yes No Unsure

Why or why not?

5. Currently, are there areas in your home that you avoid, consider unsafe, or find difficult to use?

- | | | |
|---|---|---|
| <input type="checkbox"/> Attic | <input type="checkbox"/> Dining Room | <input type="checkbox"/> Living Room |
| <input type="checkbox"/> Back Entrance | <input type="checkbox"/> Front Entrance | <input type="checkbox"/> None |
| <input type="checkbox"/> Basement | <input type="checkbox"/> Garage | <input type="checkbox"/> Outdoor Steps |
| <input type="checkbox"/> Bathroom | <input type="checkbox"/> Hallway | <input type="checkbox"/> Ramp |
| <input type="checkbox"/> Bathroom 2nd Floor | <input type="checkbox"/> Indoor Stairs | <input type="checkbox"/> Study/Den |
| <input type="checkbox"/> Bedroom | <input type="checkbox"/> Kitchen | <input type="checkbox"/> Utility/Mud Room |
| <input type="checkbox"/> Bedroom 2nd Floor | <input type="checkbox"/> Laundry Room | |

Other/Notes:

6. Are there things you think can be done to make these places or things safer and easier to use?



**Initial Assessment -
Bathroom**

7. Does anyone in the home have difficulty getting on and off of the toilet seat?

Yes

No

If Yes, how many have difficulty?

8. Does anyone have any difficulty bathing or showering? i.e. getting in and out of the bathtub/shower.

Yes

No

If Yes, how many people?

8.5 What are some medical problems that you see a primary care provider for? Please check all that apply:

Arthritis or Rheumatism

Heart Problems

Cancer

High blood pressure or hypertension

Chronic lung disease or breathing problems

Memory-related issue

Diabetes or high blood sugar

Neurological problems like stroke
TIA, MS or Parkinson's

Emotional, nervous, or psychiatric problems

Osteoporosis

Eye problems like cataracts, glaucoma, or
macular degeneration

Don't know/refused

Other - if other please specify below:



Initial Assessment - Falls and Hospital

9. In the last 6 months, has anyone in the household had a fall?

- No
- Yes
- Unknown
- Refused

If Yes, how many members of your household had a fall in the last 6 months? (DO NOT ASK IF A SINGLE HH)

10. Do you remember how many total falls a household members had in the last 6 months? (Enter "Don't Know" or "Refused" if appropriate.)

11. What was/were the main reason(s) you fell in the 6 months?

- | | | |
|---|---|---|
| <input type="checkbox"/> Blacked out or fainted | <input type="checkbox"/> Had a problem with a walking aid (walker, cane etc.) | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Don't know | <input type="checkbox"/> Had a slow reaction or reflex | <input type="checkbox"/> Slipped |
| <input type="checkbox"/> Drank too much alcohol | <input type="checkbox"/> Had weakness or numbness in one or both legs | <input type="checkbox"/> Slipped on ice |
| <input type="checkbox"/> Had a health condition | <input type="checkbox"/> Had a problem with vision | <input type="checkbox"/> Some other reason |
| <input type="checkbox"/> Had a problem hearing | <input type="checkbox"/> Hurried too much | <input type="checkbox"/> Tripped or stumbled |
| <input type="checkbox"/> Had nothing to hold onto | <input type="checkbox"/> Knocked over by someone or something | <input type="checkbox"/> Walking up or down stairs |
| <input type="checkbox"/> Had not eaten recently and had low blood sugar | <input type="checkbox"/> Lost balance | <input type="checkbox"/> Were getting up after sitting or laying down |
| <input type="checkbox"/> Had a problem with medication | <input type="checkbox"/> Not paying attention | <input type="checkbox"/> Don't know/refused |
| <input type="checkbox"/> Had a problem with footwear | <input type="checkbox"/> Playing sports | |

Notes



Initial Assessment - Falls and Hospital

12. Has anyone in your household been admitted to the hospital in the last 6 months?

No

Yes

13. How many people in your household were admitted to the hospital in the last 6 months?

14. Do you remember how many times you or a member of your household stayed overnight in the hospital?

1

4

Don't remember

2

5

Refused

3

6+

15. In the last 6 months did you call 911 for any medical, fire, or other emergencies?

None

Medical

Fire

Other (please specify)

16. Do you remember how many times you called 911 in the last 6 months?



Initial Assessment - Fire and Safety

17. In the last 6 months, has there been a fire in your home?

No

Refused

Yes

N/A

18. If yes, how many fires?

19. What was/were the causes?

20. In the 6 months, have you had a "close-call" that could have caused a fire in your home? (For example: forgot about a pan or kettle on the stove burning? Dropped burning cigarette ash onto a couch or fabric surface?)

No

Refused

Yes

N/A

21. What was/were the cause(s)?

22. Were there any close-calls with fires?

Yes

No

Don't know

Refused