

TERRIOKIDS

Physical, Occupational & Speech Therapy

Home Questionnaire

Client Name: _____ Diagnosis: _____
 Date: _____ Client age: _____
 Name of Person Completing this Form: _____ Relationship: _____

Type of Residence:

- Single Family Home
 Apartment

What floor does patient live on? _____
 Is an elevator available? No Yes
 Number of floors: _____
 Are there split levels? No Yes

N/A

Entrance:

- Front Back Garage Side

Is driveway accessible? Yes No Is slope a significant factor? Yes No

Is the entry way: paved dirt grass Other: _____

Does the patient have to manage outside stairs? Yes No How many? _____

Railing present as you go up: Right Left Both None

Can client demonstrate the ability to manage stairs safely? Yes No with: _____

How many inches is each stair? _____ Is there a ramp? Yes No

Is door accessible? Yes No with: _____

Can patient demonstrate the ability to enter and exit safely independently? Yes No with: _____

N/A

Inside Home:

Does the client have to manage stairs inside the home? Yes No

If so, how many? _____ How many inches is each stair? _____

Railing present: Right Left Both None N/A

Can client demonstrate the ability to manage stairs safely? Yes No with: _____

N/A

Hallway:

Floor Covering: Carpet Tile Linoleum Other: _____

Can client demonstrate the ability to ambulate hallway independently?: Yes No with: _____

How: Forward Backward Sideways Turn Around

Are any objects obstructing the walkway? Yes No If yes please describe:

Does necessary equipment fit through all doorways? Yes No

N/A

Bedroom:

Floor Covering: Carpet Tile Linoleum Other: _____

Can client move safely around the bedroom independently? Yes No If yes, how: _____

Can client transfer in/out of bed independently? Yes No How high is the bed? _____

Can client get clothes from dresser/closet independently? Yes No

Is the bathroom a safe distance (<15ft away) from the bed (for nighttime use)? Yes No

Previous recommended equipment: Bedside commode None Other: _____

- N/A **Bathroom:**
Floor Covering: Carpet Tile Linoleum Other: _____
Is door accessible? Yes No with: _____ Forward Sideways
Is the toilet accessible? Yes No with: _____
Type of toilet: Standard Potty Chair Other: _____
Is there anything on or over the toilet? Yes No If so, _____
Can client transfer on/off of toilet independently? Yes No
Can client safely move in the bathroom independently? Yes No with: _____
Can client safely retrieve items from drawers independently? Yes No cupboards? Yes No
Is the sink accessible? Yes No with: _____
What does the client use? stall shower tub & shower tub
Is there a: swinging door sliding doors curtain Nothing
Can client safely step over ledge independently? Yes No
 Forward Backward Sideways
Are there grab bars present? Yes No If so, where are they located? _____
Can client safely manage the faucet independently? Yes No
Previous recommended equipment: None RTS with arms TTB SC with/without back
 Handheld Shower head Grab bar (placement: _____)
With recommended equipment, can client transfer independently to/from: N/A
Toilet: Yes No Tub/Shower: Yes No

- N/A **Living Room Area:**
Floor Covering: Carpet Tile Linoleum Other: _____
Is furniture arranged to allow for accessibility? Yes No
Can client transfer independently to/from favorite chair: Yes No Sofa: Yes No
With a walker: Yes No N/A
Is favorite chair a safe height? Yes No Height of chair/sofa: _____
Can client manage the TV, radio, or other devices independently? Yes No

- N/A **Dining Room:**
Floor Covering: Carpet Tile Linoleum Other: _____
Is table accessible: Yes No
Can client transfer independently to/from chair: Yes No

- N/A **Kitchen:**
Floor Covering: Carpet Tile Linoleum Other: _____
Can patient safely open refrigerator: Yes No Cabinets: Yes No
Oven: Yes No Drawers: Yes No
Can patient reach dishes, pots, food independently? Yes No
Can patient safely use sink independently? Yes No
Can patient safely use stove/oven independently? Yes No N/A
Can patient transport items safely around kitchen independently? Yes No
Can patient safely place/remove food in oven independently? Yes No N/A

- N/A **Laundry:**
Floor Covering: Carpet Tile Linoleum Other: _____
Who will/or manages laundry? Caregiver Patient
Can client safely access laundry area independently? Yes No If yes, how: _____
Can client safely load and empty washing machine independently? Yes No
Can client safely load and empty dryer independently? Yes No
Can client safely manage the controls and doors independently? Yes No
Does the client regularly use an ironing board? Yes No If so is it kept open? Yes No

If not kept open, can client safely set up/take down ironing board independently? Yes No

Additional Rooms: _____

Please list the adaptive equipment in home and check if the equipment is owned or rented. N/A

(examples: wheelchair, walker, stander, specialized stroller, crutches, cane etc.)

Owned

Rented

- | | | |
|----------|--------------------------|--------------------------|
| 1. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Does client wear: Glasses Yes No, Hearing Aids Yes No

Emergency Concerns: N/A

Is telephone accessible throughout the home? Yes No If not, where? _____

Can client leave home in a hurry in case of emergency? Yes No

Are family, neighbor's, MD and emergency phone numbers easily accessible? Yes No

Additional Information:

Please List Goals and Priorities:

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For therapist use only: