



HOME SAFETY RISK FACTOR QUIZ

		Yes	No
1.	Are there tasks you		
a.	are doing now that cause you a lot of pain?	<input type="checkbox"/>	<input type="checkbox"/>
b.	do at home that make you feel afraid for your safety?	<input type="checkbox"/>	<input type="checkbox"/>
c.	do now that cause you a lot of difficulty, that did not seem difficult before?	<input type="checkbox"/>	<input type="checkbox"/>
d.	do that forces you to strain yourself when doing them?	<input type="checkbox"/>	<input type="checkbox"/>
e.	can't do at home anymore that you could do before?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Has your balanced declined some or alot?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Has your strength declined some or alot?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Has your ability to reach over your head or behind your back declined some or alot?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Have any of the following declined some or alot?		
a.	coordination	<input type="checkbox"/>	<input type="checkbox"/>
b.	vision	<input type="checkbox"/>	<input type="checkbox"/>
c.	hearing	<input type="checkbox"/>	<input type="checkbox"/>
d.	balance	<input type="checkbox"/>	<input type="checkbox"/>
e.	strength	<input type="checkbox"/>	<input type="checkbox"/>
f.	mental abilities	<input type="checkbox"/>	<input type="checkbox"/>
g.	energy levels	<input type="checkbox"/>	<input type="checkbox"/>
h.	concentration	<input type="checkbox"/>	<input type="checkbox"/>
7.	Do you take 4 or more medications on a regular basis?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Have you fallen within the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
a.	did you get hurt?	<input type="checkbox"/>	<input type="checkbox"/>
b.	were you able to get up without help?	<input type="checkbox"/>	<input type="checkbox"/>
c.	have you fallen more than once in the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Have you had a near fall within the last six months?	<input type="checkbox"/>	<input type="checkbox"/>
10.	Do you have to bend over a lot to do basic important daily activities?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Do you have to reach above your head a lot?	<input type="checkbox"/>	<input type="checkbox"/>
12.	Do you have a comprehensive emergency plan developed in the event of serious weather conditions, fire, power failures, and ill health, etc?	<input type="checkbox"/>	<input type="checkbox"/>
13.	Do you regularly use poorly maintained tools or equipment?	<input type="checkbox"/>	<input type="checkbox"/>
14.	Are your floors slippery or uneven?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Is your home dimly lit?	<input type="checkbox"/>	<input type="checkbox"/>

All YES answers indicate there are known risk factors that could lead to illness or injury. The more YES answers, the higher the risk. Multiple YES answers are an indicator that a careful self assessment of personal factors would be an important first step to take.

For help, consider using the [Safety Appraisal For Elders \(SAFE\)](#).