ASSESSING YOUR SURROUNDINGS

This clinical tool is designed to help people explore the many ways their surroundings affect their health. Clinical staff can assist Veterans with its completion, if desired. There are five categories, and each one has its own page of questions. The categories are:

- Living Conditions
- Work Conditions
- Exposures
- Sensory Inputs
- Emotional Surroundings

If you wish to focus on just one category, you can click on it to go directly to that page.

SUGGESTIONS FOR REVIEWING COMPLETED FORMS

- Start by considering which areas stood out most.
- After discussing answers in greater detail, consider a few specific changes that could be made, starting this week.
- Agree on a time to follow up about how things are going.
- Social workers are an excellent resource for supporting any needs that arise, particularly if social services support is needed.

LIVING CONDITIONS

Are you currently homeless? ☐ No ☐ Yes

Have you ever been homeless? ☐ No ☐ Yes If yes, when?_____

Do you like where you live? ☐ No ☐ Yes

Do you live in a ☐ House ☐ Apartment ☐ Mobile Home ☐ Condo ☐ Other

How long have you lived there? _____

Do you ☐ Rent ☐ Own

How is your home heated? ☐ Electricity ☐ Propane ☐ Natural Gas ☐ Wood ☐ Oil ☐ Other

Is there a lot of crime near your home? ☐ No ☐ Yes

Do you know your neighbors? ☐ No ☐ Yes

Have you ever fallen at home? ☐ No ☐ Yes

Do you have concerns about how clean your home is? ☐ No ☐ Yes

Do you have any items that you collect? ☐ No ☐ Yes What? _____

On a scale of 1 to 5, with 5 being "tidy", how messy is your living space?

1	2	3	4	5
Unhealthy	No floor space	Messy	Cluttered	Tidy

DO YOU CURRENTLY LIVE BY:

Heavy traffic ☐ No ☐ Yes If yes, describe _____

A farm ☐ No ☐ Yes If yes, describe _____

Polluted water ☐ No ☐ Yes If yes, describe _____

An industrial plant ☐ No ☐ Yes If yes, describe _____

Other hazards ☐ No ☐ Yes If yes, describe _____

A park/green space ☐ No ☐ Yes If yes, describe _____

AT HOME, DO YOU HAVE:

Insect pests (e.g., bedbugs, roaches)? ☐ No ☐ Yes If yes, describe _____

Guns? ☐ No ☐ Yes If yes, describe _____

Smoke detectors? ☐ No ☐ Yes

Carbon monoxide detectors? ☐ No ☐ Yes

Good drinking water? ☐ No ☐ Yes

Carpets? ☐ No ☐ Yes

Air conditioning? ☐ No ☐ Yes

WORK CONDITIONS

Are you currently unemployed? ☐ No ☐ Yes How long? _____

Have you recently been unemployed? ☐ No ☐ Yes When? _____

IF YOU ARE EMPLOYED:

Where do you work? _____

What is your job title? _____

What are your job responsibilities? _____

On a scale of 1 to 5, how well do you like your job?

1	2	3	4	5
Hate it	Put up with it	Don't mind it	I like it	I love it

Are you exposed to any hazardous chemicals at work? ☐ No ☐ Yes If yes, describe
_____

Are you exposed to excess noise at work? ☐ No ☐ Yes If yes, describe

_____

How many breaks to you take during a shift/work day? _____

Does your work cause any health problems for you? ☐ No ☐ Yes If yes, describe _____

Are you comfortable at your workspace(s)? ☐ No ☐ Yes

What would make you more comfortable? _____

Do you like your supervisor/boss? ☐ No ☐ Yes

Why or why not? _____

Do you like your coworkers? ☐ No ☐ Yes

Why or why not? _____

How would you describe your **work** environment?

Noise Level	☐ Too much	☐Moderate	☐Little	
Lighting Level	☐ Too dim	☐Too bright	☐Satisfactory	
Temperature	☐ Too hot	☐Too cold	☐Too variable	☐Satisfactory
Air Movement	☐ Drafty	☐Stuffy	☐Satisfactory	
Humidity	☐ Too moist	☐Too dry	☐ Satisfactory	
Bad smells	☐ Too many	☐Moderate	☐ Satisfactory	
Overall Comfort	☐ Poor	☐Somewhat satisfactory		☐ Satisfactory

EXPOSURES

Are you aware of any exposures to the following?

Cigarette smoke ☐ No ☐ Yes

Other types of smoke (including cannabis, wood stoves) ☐ No ☐ Yes

Agent Orange ☐ No ☐ Yes

Chemical weapons ☐ No ☐ Yes

Biological weapons ☐ No ☐ Yes

Radiation ☐ No ☐ Yes

Pesticides or herbicides (e.g., bug sprays, weed killers, flea/tick collars) ☐ No ☐ Yes

Mold ☐ No ☐ Yes

Radon ☐ No ☐ Yes

Asbestos ☐ No ☐ Yes

Lead ☐ No ☐ Yes

Other heavy metals (mercury, cadmium, etc.) ☐ No ☐ Yes

Have you had any other exposures that concern you? ☐ No ☐ Yes

Do you have any artificial materials in your body (shrapnel, pins, screws, plates, etc.)?

☐ No ☐ Yes

Do you have any allergies to things in the environment (pollen, beestings, dust mites)?

☐ No ☐ Yes

Have you ever had symptoms due to an exposure to a chemical at a level that would not bother most other people (e.g., chemical sensitivities)? ☐ No ☐ Yes

Please explain any "Yes" answers to the above questions.

_____

_____

_____

_____

_____

SENSORY INPUTS

How would you rate the following for your home/living environment?

Similar questions, related to work environment, are asked in the Work Conditions section.

GENERAL

Is your living space comfortable ☐ No ☐ Yes

Is your living space peaceful? ☐ No ☐ Yes

Do your surroundings ever make it hard for you to sleep? ☐ No ☐ Yes

Do you have light-blocking curtains where you sleep? ☐ No ☐ Yes

How is the humidity level? ☐ Too moist ☐Too dry ☐ Satisfactory

How is it in terms of air movement? ☐ Drafty ☐Stuffy ☐Satisfactory

How is the temperature? ☐ Too hot ☐Too cold ☐Too variable ☐Satisfactory

LIGHT AND COLOR

How is the overall light level in your living space? ☐ Too dim ☐Too bright ☐Satisfactory

Do you ever find that low light levels affect your mood?

SOUND

How is noise in your living space? ☐ Too much ☐Moderate ☐Little

Do you play music aloud in your living space? ☐ No ☐ Yes

SMELL

In your living area, how many bad smells are there? ☐ Too many ☐ No concerns

ART

Do you have art on display in your living space? ☐ No ☐ Yes

What types of art do you enjoy? _____

Do you play music in your living space ☐ No ☐ Yes

NATURE

Do you own one or more houseplants? ☐ No ☐ Yes

Do you have easy access to green spaces (parks, trails, beaches, etc.)? ☐ No ☐ Yes

Do you have a garden or flowerbeds? ☐ No ☐ Yes

Do you have a view of nature from your living space? ☐ No ☐ Yes

EMOTIONAL SURROUNDINGS

What percent of the time do you feel happy? _____

Name 3 things in your life that bring you happiness and/or joy:

1. _____
2. _____
3. _____

Is your neighborhood safe? ☐ No ☐ Yes

Is your living space safe? ☐ No ☐ Yes

Is anyone hurting you? ☐ No ☐ Yes

Have you been hit, kicked, punched choked, or otherwise hurt by an intimate partner?

☐ No ☐ Yes

Have you been hit, kicked, punched choked, or otherwise hurt by anyone else?

☐ No ☐ Yes

Is anyone emotionally abusive to you (do they intentionally try to hurt your feelings)?

☐ No ☐ Yes

Do you have people in your life in whom you can confide about health issues? ☐ No ☐ Yes

Do you have family living nearby? ☐ No ☐ Yes

If yes, is it good for you to have them near? ☐ No ☐ Yes

Do you have close friends? ☐ No ☐ Yes

Do you have any pets? ☐ No ☐ Yes

Do you ever experience information overload (e.g., when searching the Internet)?

☐ No ☐ Yes

Do you find it hard to unplug (e.g., turn off your phone, take a day away from email, not watch the news, avoid TV)? ☐ No ☐ Yes

How many hours a week do you spend having fun or playing? _____

Do you have enough humor and laughter in your life? ☐ No ☐ Yes

How many days of vacation do you take a year? _____

How many hours do you work in an average week? _____

How many hours do you enjoy hobbies in a given week? _____

"Assessing Your Surroundings" was written by J. Adam Rindfleisch, MPhil, MD (2014, updated 2019).

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