

# Home Environmental Checklist (HEC) Healthy Homes-II

A1. Assessor's Name: \_\_\_\_\_

A2. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

A2a. Return Visit Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (if needed)

A3. Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP code: \_\_\_\_\_

A4. Caretaker's Name: \_\_\_\_\_  
First Last

A5. Child's Name: \_\_\_\_\_  
First Last

A6. Starting Time: \_\_\_\_:\_\_\_\_ AM/PM

A7. Building construction year: \_\_\_\_\_ (via iMap) (Attach printout to paperwork)

*(During the course of the interview, record temperature below)*

O

	Living room or common family space	Child's bedroom	Hot water from kitchen sink
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A8.

Temperature a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

*Interviewer: complete this page before entering the home.*

## BUILDING EXTERIOR/OUTSIDE

1. What is the type of the building?
 

<input type="radio"/> <input type="checkbox"/> <sub>1</sub> Apartment (with 3 or more units)	<input type="checkbox"/> <sub>3</sub> Detached single house
<input type="checkbox"/> <sub>2</sub> Duplex	<input type="checkbox"/> <sub>4</sub> Trailer
  
2. Do you see any problems with the roof (for example sagging, holes, or missing materials)?
 

<input type="radio"/> <input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>9</sub> Can't see entire roof
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3. Do you see any walls with missing bricks, siding, shingles, etc.?
 

<input type="radio"/> <input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>2</sub> No
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4. Is any paint peeling or flaking on the outside of the house?
 

<input type="radio"/> <input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>2</sub> No
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5. Does water spill onto siding or foundation because of malfunctioning or absent gutters and/or downspouts?
 

<input type="radio"/> <input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>2</sub> No
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6. Is soil or vegetation in contact with the siding of the house?
 

<input type="radio"/> <input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>2</sub> No
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7. Is there accumulated garbage or debris on the property?
 

<input type="radio"/> <input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>2</sub> No
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**For interviewer to read**➤: The purpose of this interview is to collect information about your home environment as it relates to your child's asthma and safety. Some of the questions are designed to help guide the type of help you will receive. Other questions are for research purposes and will help us figure out what kind of help to give all families who have a child with asthma. You don't have to answer any question you don't want to.

**Interviewer: for this questionnaire, the methods of getting information are:**

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If there is a question you do not want to answer, please let me know and we can skip it. All of your responses are confidential and will not affect any of the services you receive at the clinic or from your provider.

After the interview questions, we will walk through several rooms in the house with you to make some observations. With your permission, we may take some pictures of your home. They will be used to show how the quality of people's housing can be improved.

**B. PARTICIPANT ACTIONS**

◀**For interviewer to read**▶: I will now ask you some questions about things some people do in their homes to help control asthma triggers. There is no right or wrong answer, just tell me what YOU do.

B1. Now please tell me some things you do to lower exposure to dust mites.

**A**     <sub>0</sub> None     <sub>9</sub> Don't know

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B2. Tell me some things you do to keep roaches out of the home.

**A**     <sub>0</sub> None     <sub>9</sub> Don't know

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B3. Tell me some things you do to keep rodents (mice and rats) out of the home.

**A**     <sub>0</sub> None     <sub>9</sub> Don't know

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B4. Tell me some things you do to keep mold and moisture out of the home.

**A**     <sub>0</sub> None     <sub>9</sub> Don't know

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B5. Tell me some things you do to keep pets from making your child's asthma worse.

**A**     <sub>0</sub> None     <sub>9</sub> Don't know

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B6. Tell me some things you do to keep pollens from making your child's asthma worse

**A**     <sub>0</sub> None     <sub>9</sub> Don't know

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B7. Some people use bleach to get rid of mold. If you do, how much bleach do you add  
A to a gallon of water to make a safe, effective mold cleaning solution?


A gallon is the size of a plastic milk jug. (*Read responses in gray*)

<sub>1</sub> Tablespoon

<sub>2</sub> Quarter cup

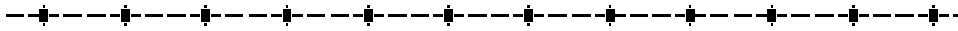
<sub>3</sub> Cup

<sub>4</sub> Quart

<sub>5</sub> Other  Specify \_\_\_\_\_

<sub>6</sub> Don't use bleach

<sub>9</sub> Don't know



### C. GENERAL QUESTIONS


<For interviewer to read>: The purpose of the following questions is to look at the environment in your home and how it relates to your child’s asthma as well as the health of other household members.

**A** C1. First, I would like to know if you did any cleaning to prepare for this visit?  
<sub>1</sub> Yes ►► If yes, how much time did you spend on it: \_\_\_\_\_ Hours \_\_\_\_\_ Min  
<sub>2</sub> No

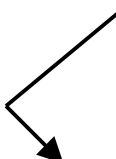
**A** C2. How many bedrooms are in the home? # \_\_\_\_\_  
*(A bedroom is a room with a window and closet in which one or more people sleep)* Enter “0” for studio.

**A** C3. Not counting bathroom(s), how many rooms are in the home? # \_\_\_\_\_

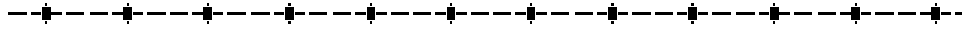
**A** C4. How many people usually live in the home? # \_\_\_\_\_  
*(including all adults and children)*

**A** C5. Where does [CHILD] usually sleep?  
<sub>1</sub> Bedroom      <sub>2</sub> Living room/family room  
<sub>3</sub> Other  Specify \_\_\_\_\_

**A** C6. Has [CHILD] ever been tested with a skin test or blood test to see what substances cause his/her allergies?  
<sub>1</sub> Yes [ ►► If yes, ask]: Where ? \_\_\_\_\_ When ? \_\_\_\_\_  
<sub>2</sub> No  
<sub>9</sub> Don’t know



*If child has been tested during the past 6 months , ask parent to sign release form so that we may get a copy of the results.*



## D. DUST AND CLEANING

◀**For interviewer to read**▶: Next, I would like to ask you some questions related to dust, cleaning, and washing.

D1. When people come into your house, do they always: *(Read responses)*

- O + A**
- a. Remove their shoes? <sub>1</sub> Yes <sub>2</sub> No
- b. Use doormat or hall rug to wipe their feet? <sub>1</sub> Yes <sub>2</sub> No

D2. Does every outside door have a doormat?

- O + A** <sub>1</sub> Yes <sub>2</sub> Some <sub>3</sub> None ➡ Skip to D4

D3. How do you clean your doormats? *(Check all that apply)*

- A**
- a.  Vacuum
- b.  Wash
- c.  Shake or Sweep
- d.  Other ➡➡ Specify \_\_\_\_\_
- e.  Don't clean

D4. Do you now have a working vacuum cleaner in the house?

- O + A** <sub>1</sub> Yes (**Check Vacuum & Collect Vacuum Bag**)
- <sub>2</sub> No ➡ Skip to D9

D5. Does it have a power head? [*EXPLAIN IF NECESSARY*: "A power head has moving brushes." ]

- O + A** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

D6. Does the vacuum have a special air filter, such as a HEPA filter, to keep dust in the vacuum?

- O** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

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◀For interviewer to read▶ The next questions are about things you did to clean your house **during the last 14 days**. [None=0, DK=99].

<u>During the LAST 14 DAYS, how many times did you or any one in the home</u>	<u>Times/14 days</u>
<b>A</b> D7. Vacuum the floor of the room in which [CHILD] sleeps?	# _____
<b>A</b> D8. Vacuum or wash the cloth-covered furniture in the home? (if no cloth covered furniture, enter 98)	# _____
<b>A</b> D9. Dust the room in which [CHILD] sleeps?	# _____
<b>A</b> D10. Scrub the tub or shower wall in the bathroom?	# _____
<b>A</b> D10a. What do you use to scrub the tub or shower wall in the bathroom? (Read choices)	
a. Tilex or other store bought cleaner.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
b. Bleach and water solution .....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
c. Detergent and water.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
d. Plain water.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
e. Other ✍ Specify _____	
<b>During the LAST 14 DAYS, how many times did you or any one in the home</b>	<b># Times/14 days</b>
<b>A</b> D11. Sweep, mop, dust or vacuum the kitchen or cooking area floor? (record the highest # of times for any of these cleaning actions)	# _____
<b>A</b> D12. Clean the kitchen counter?	# _____
<b>A</b> D13. Wash or freeze your child's stuffed animals? [If no stuffed animal, enter 98]	# _____
<b>A</b> D14. Wash your child's sheets and pillowcases?	# _____
<b>A</b> D15. Wash your child's pillows? [If no pillows, enter 98]	# _____

**A** D16 Where do you usually do your laundry?  
<sub>1</sub> At home    <sub>2</sub> In another home    <sub>3</sub> In a Laundromat    <sub>4</sub> Other

**A** D17. When you wash [CHILD]'s sheets and pillow cases what temperature do you use for the  
a. Wash cycle?    <sub>1</sub> Hot    <sub>2</sub> Warm    <sub>3</sub> Cold    <sub>9</sub> Don't Know  
b. Rinse cycle?    <sub>1</sub> Hot    <sub>2</sub> Warm    <sub>3</sub> Cold    <sub>9</sub> Don't Know




<For interviewer to read> The next set of questions will be about the last **12 months**.

**During the last 12 months, how many times did you**

**A** D18. Wash the cover on your child's bed (i.e. blankets/spreads/ comforters)?

Number of times # \_\_\_\_\_

<sub>98</sub> Other  Specify \_\_\_\_\_

<sub>99</sub> Don't know

**A** D19. Clean your carpets by:

a. Steam cleaning # \_\_\_\_\_

b. Shampooing # \_\_\_\_\_

c. Other # \_\_\_\_\_  Specify \_\_\_\_\_

d. Did not clean carpets except vacuuming

**A** D20. How do you clean area rugs? (*Check all that apply*)


a.  Vacuum surface

b.  Vacuum both sides

c.  Shake

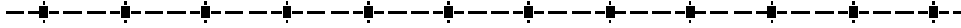
d.  Send out

e.  Wash

f.  Other...  Specify \_\_\_\_\_

g.  Don't clean them

h.  No area rug



## E. VENTILATION AND MOISTURE

<For interviewer to read>: Next are some questions about ventilation and moisture in your home.

E1. First, how often do windows other than bathroom and kitchen fog up? Would you say:

**A** (Read responses)

- |   |  |
|---|--|
| <input type="checkbox"/> <sub>5</sub> Never     | <input type="checkbox"/> <sub>2</sub> Most of the time |
| <input type="checkbox"/> <sub>4</sub> Rarely    | <input type="checkbox"/> <sub>1</sub> Always           |
| <input type="checkbox"/> <sub>3</sub> Sometimes | <input type="checkbox"/> <sub>9</sub> Don't know       |

E2. Does the bathroom window or mirror stay fogged up for more than 15 minutes

**A** after the shower is used?

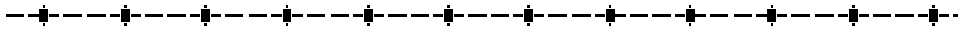
- <sub>1</sub> Yes    <sub>2</sub> No    <sub>9</sub> Don't know

E3. Do you use a humidifier/vaporizer in the home?

**A + O**    <sub>1</sub> Yes    <sub>2</sub> No    <sub>9</sub> Don't know

E4. Do you use an air conditioner in the home?

**A + O**    <sub>1</sub> Yes    <sub>2</sub> No    <sub>9</sub> Don't know



**F. PETS AND PESTS**

<For interviewer to read>: Next I would like to ask you some questions about pets, cockroaches, and mice or rats.

F1.	Do you have any pets, such as ...?	Does it come inside?	Does it come inside the child's sleeping room?
a. dogs.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
b. cats.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
c. rabbits.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
d. birds.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No		<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
e. hamsters/gerbils/other rodents	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No		<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
f. Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

Specify: \_\_\_\_\_

F2. Have you seen any cockroaches in your home during the past **three months**?

A <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

F3. Has your home been treated by a pest control company for roaches during the past **year**?

A <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

F4. Have you personally treated your home for roaches in the past **year**?

A <sub>1</sub> Yes <sub>2</sub> No ➔Skip to F6

F5. What did you use to treat your home for roaches? (*Check all that apply*)

A  Dry powder  Roach bait trap  
 Spraying  Gel ➔➔ What type/brand: \_\_\_\_\_  
 Other ➔➔ Specify: \_\_\_\_\_  
 Don't Know

F6. Have you had any problems with mice or rats in your home during the past **three months**?

A <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

F7. Has your home been treated by a pest control company for rats or mice in the **past year**?

A <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

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## Home Walk-Through

◀For interviewer to read▶ Now I would like to walk through several rooms of your home with you. I will be making observations, looking under sinks in the kitchen and bathroom, and recording information about these rooms. I will also be asking you questions related to specific items in some of the rooms we will be surveying. Is it okay to start with your child's bedroom?



### H. CHILD'S BEDROOM/SLEEPING AREA

H1. What does [CHILD] usually sleep on?

- A + O**    <sub>1</sub> Bed with mattress    <sub>2</sub> Mattress on floor  
<sub>3</sub> Other ... ✍ Specify \_\_\_\_\_

H2. What types of blankets/bedcovers do you use on his/her bed? (Check all that are present)

- A + O**     a. Comforter                                     d. Acrylic blanket  
 b. Wool blanket                                         e. Fleece  
 c. Cotton blanket                                         f. Don't Know

H3. At what temperature do you keep this room during the heating season? \_\_\_\_\_ °F

**A** (Enter 98 if the heater does not work)

**A** H4. During the heating season, does this room ever get cold enough to make someone uncomfortable for 24 hours or more?                                    <sub>1</sub> Yes    <sub>2</sub> No    <sub>9</sub> Don't know

**O** H5. Is the gap under the bedroom door at least 1"?                                    <sub>1</sub> Yes    <sub>2</sub> No    <sub>3</sub> No door

**A + O** H6. Does the object (bed, mattress, etc.) on which [CHILD] usually sleeps have a zippered allergy control cover? ?                                    <sub>1</sub> Yes    <sub>2</sub> No

**A + O** H7. Does the pillow have a zippered allergy control cover?                                    <sub>1</sub> Yes    <sub>2</sub> No    <sub>3</sub> No pillow

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Interviewers: Please complete the HOME ASSESSMENT CHECK LIST for child's bedroom/sleeping area. All questions are "O" except where "ASK" is stated.

Child's Bedroom	Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> <sub>1</sub> Carpeting <input type="checkbox"/> <sub>2</sub> Hardwood, tile, linoleum or vinyl <input type="checkbox"/> <sub>3</sub> Other
Carpet type:	<input type="checkbox"/> <sub>1</sub> Level loop <input type="checkbox"/> <sub>2</sub> Shag or plush
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condition of carpet:	<input type="checkbox"/> <sub>1</sub> Good <input type="checkbox"/> <sub>2</sub> Fair <input type="checkbox"/> <sub>3</sub> Poor
Area rugs? ▶▶ If yes, % of floor area covered	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> 1/4 <input type="checkbox"/> <sub>2</sub> 1/2 <input type="checkbox"/> <sub>3</sub> 3/4 <input type="checkbox"/> <sub>4</sub> All
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
Can at least one window be opened?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<u>Ask:</u> When weather allows, do you open the window to ventilate?	<input type="checkbox"/> <sub>1</sub> Always <input type="checkbox"/> <sub>2</sub> Most times <input type="checkbox"/> <sub>3</sub> Sometimes <input type="checkbox"/> <sub>4</sub> Never
Types of window covering:	<input type="checkbox"/> <sub>1</sub> Curtains/drapes <input type="checkbox"/> <sub>2</sub> Blinds or shades <input type="checkbox"/> <sub>9</sub> Not applicable
Is the window fall-proof?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

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Child's Bedroom	Mark Correct Answer
Notice any <b>electrical cords</b> in poor condition?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Do radiators have safety covers?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Not Applicable
<b>Working air cleaner in the room?</b>  ▶▶ Does it have a HEPA filter?	<input type="checkbox"/> <sub>1</sub> Yes; capacity _____ cu.ft. <input type="checkbox"/> <sub>2</sub> No  <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Level of dust on surface in the room</b>	<input type="checkbox"/> <sub>1</sub> None <input type="checkbox"/> <sub>2</sub> Slight <input type="checkbox"/> <sub>3</sub> Moderate <input type="checkbox"/> <sub>4</sub> Heavy
<b>Is this room above ground?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

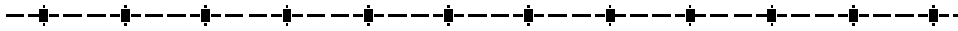
<p><b><u>Structural problems</u></b></p> <p>Cracks (larger than thickness of a dime)    <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>2</sub> No</p> <p>Holes    <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>2</sub> No</p> <p>Peeling paint    <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>2</sub> No</p> <p>Other    <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>2</sub> No</p> <p>    ▶▶ If yes, specify: _____</p>	
<p>▶▶ If any structural problems, mold or leak, <u>ask</u>:</p> <p>    Have you tried to fix the problem yourself?    <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>2</sub> No</p> <p>        ▶▶ If yes, what did you do?</p> <p>            _____</p> <p>            _____</p> <p>    Have you asked your landlord to fix the problem?    <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>2</sub> No</p> <p>        ▶▶ If yes, what did he/she do?</p> <p>            _____</p> <p>            _____</p> <p>            _____</p>	

Child's Bedroom	Mark Correct Answer
<b>Are any of the following odors present?</b>	
Tobacco	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Mold	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Sewer	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Fragrance (air freshener)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Candles/incense	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Strong smelling cleaner or chemical	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No    ▶▶ If yes, specify below:
<b>See evidence of</b> (in the room and closet)	
Water damage	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condensation	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Window type	<input type="checkbox"/> <sub>1</sub> Single pane <input type="checkbox"/> <sub>2</sub> Double pane
Water leaks/drips	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Water leak source	<input type="checkbox"/> <sub>1</sub> Outside <input type="checkbox"/> <sub>2</sub> Inside <input type="checkbox"/> <sub>3</sub> Both
<b>See evidence of</b> (in the room and closet)	
<b>Mold/mildew</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No    ▶▶ If yes, record items below
<b>Location &amp; size</b>	
Wall/ceiling	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Carpet	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Window tracks	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Other _____	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe

<b>See evidence of</b> (in the room and closet)	
Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Rodents (or droppings)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food debris: crumbs, scraps on counter or floor, overflowing trash can	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food stored unsealed	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Non-food clutter	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

**Interviewer: for this questionnaire, the methods of getting information are:**

**O = observation only, A = ask client, A+O = ask and observe**



### I. LIVING ROOM/FAMILY ROOM

◀For interviewer to read▶ Next, let's have a look at the living room.

Please complete the **HOME ASSESSMENT CHECK LIST** for the living room or family room.

Living Room/Family Room	Mark Correct Answer
<b>Type of floor covering:</b>	<input type="checkbox"/> <sub>1</sub> Carpeting <input type="checkbox"/> <sub>2</sub> Hardwood, tile, linoleum or vinyl <input type="checkbox"/> <sub>3</sub> Other
<b>Carpet type:</b>	<input type="checkbox"/> <sub>1</sub> Level loop <input type="checkbox"/> <sub>2</sub> Shag or plush
<b>Is the carpet damp to touch?</b> ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Condition of carpet:</b>	<input type="checkbox"/> <sub>1</sub> Good <input type="checkbox"/> <sub>2</sub> Fair <input type="checkbox"/> <sub>3</sub> Poor
<b>Area rugs?</b> ▶▶ If yes, % of floor area covered	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> 1/4 <input type="checkbox"/> <sub>2</sub> 1/2 <input type="checkbox"/> <sub>3</sub> 3/4 <input type="checkbox"/> <sub>4</sub> All
<b>Cloth-covered furniture?</b> ▶▶ If yes, how many pieces?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
<b>Stuffed toys?</b> ▶▶ If yes, how many toys?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
<b>Can at least one window be opened?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Ask:</b> When weather allows, do you <b>open the window to ventilate?</b>	<input type="checkbox"/> <sub>1</sub> Always <input type="checkbox"/> <sub>2</sub> Most times <input type="checkbox"/> <sub>3</sub> Sometimes <input type="checkbox"/> <sub>4</sub> Never
<b>Types of window covering:</b>	<input type="checkbox"/> <sub>1</sub> Curtains/drapes <input type="checkbox"/> <sub>2</sub> Blinds or shades <input type="checkbox"/> <sub>9</sub> Not applicable
<b>Is the window fall-proof?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

**Interviewer: for this questionnaire, the methods of getting information are:**

**O = observation only, A = ask client, A+O = ask and observe**



Living Room/Family Room	Mark Correct Answer
Notice any <b>electrical cords</b> in poor condition?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Do radiators have safety covers?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Not Applicable
<b>Working air cleaner in the room?</b>  ▶▶ Does it have a HEPA filter?	<input type="checkbox"/> <sub>1</sub> Yes; capacity _____ cu.ft. <input type="checkbox"/> <sub>2</sub> No  <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Level of dust on surface in the room</b>	<input type="checkbox"/> <sub>1</sub> None <input type="checkbox"/> <sub>2</sub> Slight <input type="checkbox"/> <sub>3</sub> Moderate <input type="checkbox"/> <sub>4</sub> Heavy
<b>Is this room above ground?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

Structural problems	
Cracks (larger than thickness of a dime)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Holes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Peeling paint	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, specify:	_____
▶▶ If any structural problems, mold or leak, <i>ask</i> : Have you tried to fix the problem yourself?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, what did you do?	_____
	_____
Have you asked your landlord to fix the problem?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, what did he/she do?	_____
	_____
	_____

**Interviewer: for this questionnaire, the methods of getting information are:**

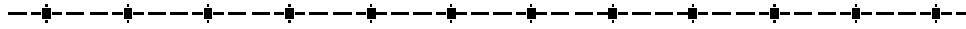
**O = observation only, A = ask client, A+O = ask and observe**

Living Room/Family Room	Mark Correct Answer
<b>Are any of the following odors present?</b>	
Tobacco	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Mold	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Sewer	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Fragrance (air freshener)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Candles/incense	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Strong smelling cleaner or chemical	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No    ▶▶ If yes, specify below:
<b>See evidence of</b> (in the room and closet)	
Water damage	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condensation	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Window type	<input type="checkbox"/> <sub>1</sub> Single pane <input type="checkbox"/> <sub>2</sub> Double pane
Water leaks/drips	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Water leak source	<input type="checkbox"/> <sub>1</sub> Outside <input type="checkbox"/> <sub>2</sub> Inside <input type="checkbox"/> <sub>3</sub> Both
<b>See evidence of</b> (in the room and closet)	
<b>Mold/mildew</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No    ▶▶ If yes, record items below
<b>Location &amp; size/ Intensity</b>	
Wall/ceiling	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Carpet	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Window tracks	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Other _____	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe

<b>See evidence of</b> (in the room and closet)	
Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Rodents (or droppings)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food debris: crumbs, scraps on counter or floor, overflowing trash can	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food stored unsealed	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Non-food clutter	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

**Interviewer: for this questionnaire, the methods of getting information are:**

**O = observation only, A = ask client, A+O = ask and observe**



## J. THE KITCHEN

◀For interviewer to read▶ Next, let's have a look at the kitchen.

J1. What kind of heat source do you cook with?

- A + O**    <sub>1</sub> Gas                      <sub>2</sub> Electric    ➡ Skip to J2  
<sub>3</sub> Other    ↙ Specify \_\_\_\_\_    ➡ Skip to J2

J1a. If gas, is stove ever used to heat your home?

- A**            <sub>1</sub> Yes      <sub>2</sub> No      <sub>9</sub> Don't know

J2. Is there a hood/vent with a working fan present over the stove/oven? (*Turn on fan to test*)

- A + O**    <sub>1</sub> Yes    <sub>2</sub> No    ➡ Skip to CHECKLIST    <sub>9</sub> Don't know    ➡ Skip to CHECKLIST

J2a. Is the hood or vent over the stove ventilated to the outside?

- A + O**    (*Look at outside wall if possible to see if vent is in place*)  
<sub>1</sub> Yes      <sub>2</sub> No      <sub>9</sub> Don't know

J2b. How often is the fan or vent used when the stove is in use? Would you say:

- A**            <sub>1</sub> Always                                      <sub>4</sub> Rarely  
<sub>2</sub> Most of the time                                      <sub>5</sub> Never  
<sub>3</sub> Sometimes    <sub>9</sub> Don't Know

J2c. Do the toilet paper test: Is the suction in the fan adequate?

- O**            <sub>1</sub> Yes      <sub>2</sub> No      <sub>9</sub> Don't know



Please complete the home assessment **CHECKLIST** for the kitchen.  
Remember to measure **hot water temperature** and record on the face sheet.

Kitchen	Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> <sub>1</sub> Carpeting <input type="checkbox"/> <sub>2</sub> Hardwood, tile, linoleum or vinyl <input type="checkbox"/> <sub>3</sub> Other
Carpet type:	<input type="checkbox"/> <sub>1</sub> Level loop <input type="checkbox"/> <sub>2</sub> Shag or plush
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condition of carpet:	<input type="checkbox"/> <sub>1</sub> Good <input type="checkbox"/> <sub>2</sub> Fair <input type="checkbox"/> <sub>3</sub> Poor
Area rugs? ▶▶ If yes, % of floor area covered	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> 1/4 <input type="checkbox"/> <sub>2</sub> 1/2 <input type="checkbox"/> <sub>3</sub> 3/4 <input type="checkbox"/> <sub>4</sub> All
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
Can at least one window be opened?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<u>Ask:</u> When weather allows, do you open the window to ventilate?	<input type="checkbox"/> <sub>1</sub> Always <input type="checkbox"/> <sub>2</sub> Most times <input type="checkbox"/> <sub>3</sub> Sometimes <input type="checkbox"/> <sub>4</sub> Never
Types of window covering:	<input type="checkbox"/> <sub>1</sub> Curtains/drapes <input type="checkbox"/> <sub>2</sub> Blinds or shades <input type="checkbox"/> <sub>9</sub> Not applicable
Is the window fall-proof?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

Interviewer: for this questionnaire, the methods of getting information are:

**O = observation only, A = ask client, A+O = ask and observe**

<b>Kitchen</b>	<b>Mark Correct Answer</b>
Notice any <b>electrical cords</b> in poor condition?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Do radiators have safety covers?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Not Applicable
<b>Working air cleaner in the room?</b>	<input type="checkbox"/> <sub>1</sub> Yes: capacity _____ cu.ft. <input type="checkbox"/> <sub>2</sub> No
▶▶ Does it have a HEPA filter?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Level of dust on surface in the room</b>	<input type="checkbox"/> <sub>1</sub> None <input type="checkbox"/> <sub>2</sub> Slight <input type="checkbox"/> <sub>3</sub> Moderate <input type="checkbox"/> <sub>4</sub> Heavy
<b>Is this room above ground?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

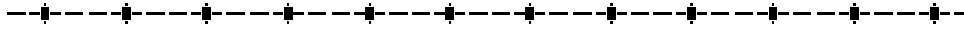
<b><u>Structural problems</u></b>	
Cracks (larger than thickness of a dime)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Holes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Peeling paint	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	
▶▶ If yes, specify:	_____
▶▶ If any structural problems, mold or leak, <i>ask</i> :	
Have you tried to fix the problem yourself?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, what did you do?	_____
	_____
Have you asked your landlord to fix the problem?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, what did he/she do?	_____
	_____
	_____

Kitchen	Mark Correct Answer
<b>Are any of the following odors present?</b>	
Tobacco	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Mold	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Sewer	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Fragrance (air freshener)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Candles/incense	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Strong smelling cleaner or chemical	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No    ▶▶ If yes, specify below:
<b>See evidence of</b> (in the room and closet)	
Water damage	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condensation	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Window type	<input type="checkbox"/> <sub>1</sub> Single pane <input type="checkbox"/> <sub>2</sub> Double pane
Water leaks/drips	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Water leak source	<input type="checkbox"/> <sub>1</sub> Outside <input type="checkbox"/> <sub>2</sub> Inside <input type="checkbox"/> <sub>3</sub> Both
<b>See evidence of</b> (in the room and closet)	
<b>Mold/mildew</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No    ▶▶ If yes, record items below
<b>Location &amp; size/ Intensity</b>	
Wall/ceiling	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Carpet	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Window tracks	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Other _____	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No ▶▶ If yes, rate intensity <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe

<b>See evidence of</b> (in the room and closet)	
Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Rodents (or droppings)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food debris: crumbs, scraps on counter or floor, overflowing trash can	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food stored unsealed	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Non-food clutter	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

**Interviewer: for this questionnaire, the methods of getting information are:**

**O = observation only, A = ask client, A+O = ask and observe**



## K. THE BATHROOM

◀**For interviewer to read**▶ Let's visit the bathroom [CHILD] uses most

K1. Is there a working fan in the bathroom? (*Turn on the fan to test*)

**A + O**      <sub>1</sub> Yes      <sub>2</sub> No      ➡ Skip to K2

K1a. ▶▶ If yes, how often is the fan used during and after a shower? Would you say:

**A**

<input type="checkbox"/> <sub>1</sub> Always	<input type="checkbox"/> <sub>4</sub> Rarely
<input type="checkbox"/> <sub>2</sub> Most of the time	<input type="checkbox"/> <sub>5</sub> Never
<input type="checkbox"/> <sub>3</sub> Sometimes	<input type="checkbox"/> <sub>9</sub> Don't Know

K1b. Do the toilet paper test: Is the suction in the fan adequate?

**A + O**      <sub>1</sub> Yes      <sub>2</sub> No

K1c. Is the fan vented to the outside? (*Check outside to see if vent is visible*)

**A**      <sub>1</sub> Yes      <sub>2</sub> No      <sub>9</sub> Don't know

K2. Are there cracks or spaces around the tub, shower or sink caused by inadequate caulking, missing tiles, etc.?

**O**      <sub>1</sub> Yes      <sub>2</sub> No



Please complete the home assessment **CHECKLIST** for the bathroom.

Bathroom	Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> <sub>1</sub> Carpeting <input type="checkbox"/> <sub>2</sub> Hardwood, tile, linoleum or vinyl <input type="checkbox"/> <sub>3</sub> Other
Carpet type:	<input type="checkbox"/> <sub>1</sub> Level loop <input type="checkbox"/> <sub>2</sub> Shag or plush
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condition of carpet:	<input type="checkbox"/> <sub>1</sub> Good <input type="checkbox"/> <sub>2</sub> Fair <input type="checkbox"/> <sub>3</sub> Poor
Area rugs? ▶▶ If yes, % of floor area covered	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> 1/4 <input type="checkbox"/> <sub>2</sub> 1/2 <input type="checkbox"/> <sub>3</sub> 3/4 <input type="checkbox"/> <sub>4</sub> All
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
Can at least one window be opened?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<u>Ask:</u> When weather allows, do you open the window to ventilate?	<input type="checkbox"/> <sub>1</sub> Always <input type="checkbox"/> <sub>2</sub> Most times <input type="checkbox"/> <sub>3</sub> Sometimes <input type="checkbox"/> <sub>4</sub> Never
Types of window covering:	<input type="checkbox"/> <sub>1</sub> Curtains/drapes <input type="checkbox"/> <sub>2</sub> Blinds or shades <input type="checkbox"/> <sub>3</sub> Not applicable
Is the window fall-proof?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

Interviewer: for this questionnaire, the methods of getting information are:

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**O** = observation only, **A** = ask client, **A+O** = ask and observe

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Bathroom	Mark Correct Answer
Notice any <b>electrical cords</b> in poor condition?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Do radiators have safety covers?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Not Applicable
<b>Working air cleaner in the room?</b>	<input type="checkbox"/> <sub>1</sub> Yes; capacity _____ cu.ft. <input type="checkbox"/> <sub>2</sub> No
▶▶ Does it have a HEPA filter?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Level of dust on surface in the room</b>	<input type="checkbox"/> <sub>1</sub> None <input type="checkbox"/> <sub>2</sub> Slight <input type="checkbox"/> <sub>3</sub> Moderate <input type="checkbox"/> <sub>4</sub> Heavy
<b>Is this room above ground?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

<b>ASK:</b> Have you had flooding or sewer backup?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
If had damaged material as a result, has the material been disinfected or removed?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

<b><u>Structural problems</u></b>	
Cracks (larger than thickness of a dime)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Holes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Peeling paint	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, specify: _____	
▶▶ If any structural problems, mold or leak, <u>ask:</u>	
Have you tried to fix the problem yourself?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, what did you do?	_____
	_____
Have you asked your landlord to fix the problem?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, what did he/she do?	_____
	_____
	_____

Bathroom	Mark Correct Answer
<b>Are any of the following odors present?</b>	
Tobacco	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Mold	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Sewer	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Fragrance (air freshener)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Candles/incense	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Strong smelling cleaner or chemical	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <b>▶▶ If yes, specify below:</b>

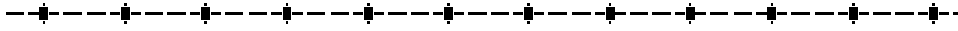
<b>See evidence of</b> (in the room and closet)	
Water damage	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condensation	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Window type	<input type="checkbox"/> <sub>1</sub> Single pane <input type="checkbox"/> <sub>2</sub> Double pane
Water leaks/drips	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Water leak source	<input type="checkbox"/> <sub>1</sub> Outside <input type="checkbox"/> <sub>2</sub> Inside <input type="checkbox"/> <sub>3</sub> Both

<b>See evidence of</b> (in the room and closet)	
<b>Mold/mildew</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <b>▶▶ If yes, record items below</b>
<b>Location &amp; size/ Intensity</b>	
Wall/ceiling	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No <b>▶▶ If yes, rate intensity</b> <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Carpet	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No <b>▶▶ If yes, rate intensity</b> <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Window tracks	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No <b>▶▶ If yes, rate intensity</b> <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Other _____	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No <b>▶▶ If yes, rate intensity</b> <input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe

<b>See evidence of</b> (in the room and closet)	
Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Rodents (or droppings)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food debris: crumbs, scraps on counter or floor, overflowing trash can	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food stored unsealed	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Non-food clutter	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

**Interviewer: for this questionnaire, the methods of getting information are:**

**O = observation only, A = ask client, A+O = ask and observe**



## L. BASEMENT or CRAWL SPACE

L1. Do you have a basement in the home?

**A + O**   <sub>1</sub> Yes      <sub>2</sub> No ➡ Skip to L6

L2. Is there access to the basement from inside the home?

**A + O**   <sub>1</sub> Yes      <sub>2</sub> No

L3. Is food stored in basement?

**A + O**   <sub>1</sub> Yes      <sub>2</sub> No

L3a. ▶▶ If yes, is it in sealed container?

<sub>1</sub> Yes      <sub>2</sub> No

L4. Is the basement floor bare concrete or finished (i.e. carpeted/walled etc.)?

- O**   <sub>1</sub> Dirt /soil ➡ Skip to CHECKLIST.  
<sub>2</sub> Finished  
<sub>9</sub> Don't know

L5. If the basement floor is carpeted, is there a vapor barrier under the carpet?

**A + O**   <sub>1</sub> Yes      <sub>2</sub> No      <sub>9</sub> Don't know      <sub>8</sub> Not carpeted

***Stop and go to the checklist for the basement***

---

L6. Is there a crawl space under the house?

**A + O**   <sub>1</sub> Yes   <sub>2</sub> No   ➡ Skip to CHECKLIST

L7. Does the crawl space have vents?

**A + O**   <sub>1</sub> Yes   <sub>2</sub> No

L8. Is the crawl space wet or damp?

**A + O**   <sub>1</sub> Yes   <sub>2</sub> No   <sub>3</sub> Can't access

L9. Is there a moisture barrier in the crawl space?

**A + O**   <sub>1</sub> Yes   <sub>2</sub> No   <sub>3</sub> Can't access

L10. Is there debris in the crawl space?

**A + O**   <sub>1</sub> Yes   <sub>2</sub> No   <sub>3</sub> Can't access

➡ Please complete the home assessment **CHECKLIST** for the **basement** if basement is used as a living space. If the basement is **not** used for living space, answer questions in the **odor and evidence boxes only**.

Basement	Mark Correct Answer
Type of floor covering:	<input type="checkbox"/> <sub>1</sub> Carpeting <input type="checkbox"/> <sub>2</sub> Hardwood, tile, linoleum or vinyl <input type="checkbox"/> <sub>3</sub> Other
Carpet type:	<input type="checkbox"/> <sub>1</sub> Level loop <input type="checkbox"/> <sub>2</sub> Shag or plush
Is the carpet damp to touch? ▶▶ If yes, ask: more than 48 hours?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condition of carpet:	<input type="checkbox"/> <sub>1</sub> Good <input type="checkbox"/> <sub>2</sub> Fair <input type="checkbox"/> <sub>3</sub> Poor
Area rugs? ▶▶ If yes, % of floor area covered	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>1</sub> 1/4 <input type="checkbox"/> <sub>2</sub> 1/2 <input type="checkbox"/> <sub>3</sub> 3/4 <input type="checkbox"/> <sub>4</sub> All
Cloth-covered furniture? ▶▶ If yes, how many pieces?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
Stuffed toys? ▶▶ If yes, how many toys?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No # _____
Can at least one window be opened?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<u>Ask:</u> When weather allows, do you <b>open the window to ventilate</b> ?	<input type="checkbox"/> <sub>1</sub> Always <input type="checkbox"/> <sub>2</sub> Most times <input type="checkbox"/> <sub>3</sub> Sometimes <input type="checkbox"/> <sub>4</sub> Never
Types of window covering:	<input type="checkbox"/> <sub>1</sub> Curtains/drapes <input type="checkbox"/> <sub>2</sub> Blinds or shades <input type="checkbox"/> <sub>9</sub> Not applicable

Basement	Mark Correct Answer
Notice any <b>electrical cords</b> in poor condition?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Do radiators have safety covers?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Not Applicable
<b>Working air cleaner in the room?</b>	<input type="checkbox"/> <sub>1</sub> Yes; capacity _____ cu.ft. <input type="checkbox"/> <sub>2</sub> No
▶▶ Does it have a HEPA filter?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>Level of dust on surface in the room</b>	<input type="checkbox"/> <sub>1</sub> None <input type="checkbox"/> <sub>2</sub> Slight <input type="checkbox"/> <sub>3</sub> Moderate <input type="checkbox"/> <sub>4</sub> Heavy
<b>Is this room above ground?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

<b>ASK:</b> Have you had flooding or sewer backup?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
If had damaged material as a result, has the material been disinfected or removed?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

<b><u>Structural problems</u></b>	
Cracks (larger than thickness of a dime)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Holes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Peeling paint	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, specify: _____	
▶▶ If any structural problems, mold or leak, <i>ask</i> :	
Have you tried to fix the problem yourself?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, what did you do?	_____
_____	
Have you asked your landlord to fix the problem?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
▶▶ If yes, what did he/she do?	_____
_____	
_____	

➡ **Odor & evidence boxes follow – complete these sections for basements used as living space.**

<b>Basement</b>	<b>Mark Correct Answer</b>
<b><u>Are any of the following odors present?</u></b>	
Tobacco	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Mold	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Sewer	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Fragrance (air freshener)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Candles/incense	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Strong smelling cleaner or chemical	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Other	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No    ▶▶ If yes, specify below: _____
<b><u>See evidence of</u></b> (in the room and closet)	
Water damage	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Condensation	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Window type	<input type="checkbox"/> <sub>1</sub> Single pane <input type="checkbox"/> <sub>2</sub> Double pane
Water leaks/drips	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Water leak source	<input type="checkbox"/> <sub>1</sub> Outside <input type="checkbox"/> <sub>2</sub> Inside <input type="checkbox"/> <sub>3</sub> Both
<b><u>See evidence of</u></b> (in the room and closet)	
<b>Mold/mildew</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No    ▶▶ If yes, record items below
<b>Location &amp; size/ Intensity</b>	
Wall/ceiling	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No
	▶▶ If yes, rate intensity
	<input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Carpet	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No
	▶▶ If yes, rate intensity
	<input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Window tracks	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No
	▶▶ If yes, rate intensity
	<input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe
Other _____	<input type="checkbox"/> <sub>1</sub> Yes _____ (inches/feet/yards) <input type="checkbox"/> <sub>2</sub> No
	▶▶ If yes, rate intensity
	<input type="checkbox"/> <sub>1</sub> Slight <input checked="" type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe

<b><u>See evidence of</u></b> (in the room and closet)	
Cockroaches (include eggs, feces, insects)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Rodents (or droppings)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food debris: crumbs, scraps on counter or floor, overflowing trash can	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Food stored unsealed	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Non-food clutter	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
Cigarette butts, ashtrays with ashes	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No

**Interviewer: for this questionnaire, the methods of getting information are:**

**O = observation only, A = ask client, A+O = ask and observe**





**M. HEAT SOURCE** (Use the table below to record answers)

◀For interviewer to read▶ Next, I would like to ask you some questions about the heat sources in your home.

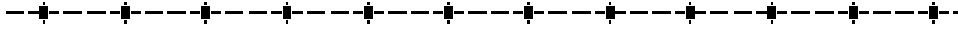
<b>A + O</b> <b>QUESTIONS TO</b> <b>THE RIGHT</b>	M1. Heat Source <b>A + O</b>	M1a. Vented to the outside <b>A + O</b>	M1b. Times used per week <b>A</b>	M2. Filter on air intake <b>A + O</b>	M2a. How clean? <b>O</b>	M2b. Filter type <b>O</b>	M3. How often do you smell fuel? <b>A</b>
<b>a1.</b> Electric – baseboard	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No						
<b>a2.</b> Electric – furnace	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No			<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know	<input type="checkbox"/> <sub>1</sub> Clean <input type="checkbox"/> <sub>2</sub> Partially dirty <input type="checkbox"/> <sub>3</sub> Dirty <input type="checkbox"/> <sub>4</sub> Unable to observe	<input type="checkbox"/> <sub>1</sub> Pleated <input type="checkbox"/> <sub>2</sub> Electro-static <input type="checkbox"/> <sub>3</sub> Unable to observe	
<b>b.</b> Gas	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know		<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know	<input type="checkbox"/> <sub>1</sub> Clean <input type="checkbox"/> <sub>2</sub> Partially dirty <input type="checkbox"/> <sub>3</sub> Dirty <input type="checkbox"/> <sub>4</sub> Unable to observe	<input type="checkbox"/> <sub>1</sub> Pleated <input type="checkbox"/> <sub>2</sub> Electro-static <input type="checkbox"/> <sub>3</sub> Unable to observe	<input type="checkbox"/> <sub>1</sub> Never <input type="checkbox"/> <sub>2</sub> Sometimes <input type="checkbox"/> <sub>3</sub> Often
<b>c.</b> Oil	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know		<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know	<input type="checkbox"/> <sub>1</sub> Clean <input type="checkbox"/> <sub>2</sub> Partially dirty <input type="checkbox"/> <sub>3</sub> Dirty <input type="checkbox"/> <sub>4</sub> Unable to observe	<input type="checkbox"/> <sub>1</sub> Pleated <input type="checkbox"/> <sub>2</sub> Electro-static <input type="checkbox"/> <sub>3</sub> Unable to observe	<input type="checkbox"/> <sub>1</sub> Never <input type="checkbox"/> <sub>2</sub> Sometimes <input type="checkbox"/> <sub>3</sub> Often
<b>d.</b> Wood stove fireplace	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know	<input type="checkbox"/> <sub>1</sub> Daily <input type="checkbox"/> <sub>2</sub> Occasionally				<input type="checkbox"/> <sub>1</sub> Never <input type="checkbox"/> <sub>2</sub> Sometimes <input type="checkbox"/> <sub>3</sub> Often
<b>e.</b> Other (↻Specify): (eg. kerosene, gas fireplace, propane heat)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know	<input type="checkbox"/> <sub>1</sub> Daily <input type="checkbox"/> <sub>2</sub> Occasionally				<input type="checkbox"/> <sub>1</sub> Never <input type="checkbox"/> <sub>2</sub> Sometimes <input type="checkbox"/> <sub>3</sub> Often

*Interviewer: for this questionnaire, the methods of getting information are:*

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## N. PAINT

◀**For interviewer to read**▶ Now I have a few questions about paint inside and outside your home.

N1. Has there been remodeling or paint removal on the inside or outside of your home in the last two years?

*(If apartment, include inside spaces of building such as lobby or hallway)*

**A**      <sub>1</sub> Yes      <sub>2</sub> No      <sub>9</sub> Don't know

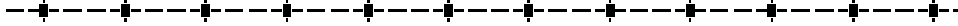
N2. Are you or your landlord planning to remodel or repaint within the next 12 months?

**A**      <sub>1</sub> Yes      <sub>2</sub> No      <sub>9</sub> Don't know

*Interviewer: for this questionnaire, the methods of getting information are:*

**O = observation only, A = ask client, A+O = ask and observe**

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## O. OTHER

◀For interviewer to read▶ Now, some other questions.

O1. Do you have a working clothes dryer in the home?

**A** <sub>1</sub> Yes <sub>2</sub> No ➡ Skip to O2

O1a. Is it vented on the outside? (*Check on outside wall to see if there is a vent*)

**A + O** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

O1b. Does it have a working lint filter?

**A + O** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

O2. Does your building have asbestos (furnace insulation, "popcorn" ceiling)?

**A + O** <sub>1</sub> Yes <sub>2</sub> No ➡ Skip to O3 <sub>9</sub> Don't know ➡ Skip to O3

O2a. ▶▶ If yes, is the surface of the asbestos in good condition?

**A + O** (i.e., not damaged, loose, or flaking)  
<sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

O3. Is there any room that is slab on grade?

**A + O** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

O4. Is there any room that is below ground?

**A + O** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

O5. Overall, how satisfied are you with your home?

**A + O** <sub>1</sub> Very satisfied  
<sub>2</sub> Somewhat satisfied  
<sub>3</sub> Somewhat unsatisfied  
<sub>4</sub> Very unsatisfied

**Interviewer: for this questionnaire, the methods of getting information are:**  
**O = observation only, A = ask client, A+O = ask and observe**

**P. CHEMICALS AND IRRITANTS**

P1. Are there any of the following products used in the home?

<b>A + O &lt;Ask to look in closets, under sinks or other places that hazardous products might be stored&gt;</b>	
a. Bleach products other than laundry bleach ..... (e.g. disinfectants, mildew remover, tile cleaners)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
b. Ammonia cleaners.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
c. Detergent product (Spic & Span, Mr. Clean).....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
d. Oil-based paints and stains.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
e. Paint thinners and solvents.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
f. Paint removers.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
g. Cleaners (drain, oven, toilet cleaners with DANGER sign).	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
h. Air fresheners/purifiers.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
i. Adhesives (e. g. rubber cement, plastic glue, spray-on glue)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
j. Spot removers.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
k. Spray lubricants.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
l. Furniture polish/spray.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
m. Permanent or whiteboard markers.....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
n. Disinfectants (Lysol, Pinesol, etc.).....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know
o. Pesticides (Specify).....	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No <input type="checkbox"/> <sub>9</sub> Don't know

**Interviewer: for this questionnaire, the methods of getting information are:  
O = observation only, A = ask client, A+O = ask and observe**

Are there any:	P2	P3	P4
<b>A + O</b>	Flammable products stored near fire or heat?	Hazardous products within reach of children?	Damaged, rusting, leaking or open containers of hazardous products?
	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>2</sub> No
<b>If yes:</b>			
What is the product?			
Where is it stored?			

P5. Are there any non-asthma medicines in the home accessible to children?

- A** <sub>1</sub> Yes  Specify names of medicine \_\_\_\_\_  
<sub>2</sub> No

P6. Is there a place to store chemicals that is separated from the living area so that fumes cannot get into the living space, such as a shed or detached garage?

- A** <sub>1</sub> Yes  Specify location \_\_\_\_\_  
<sub>2</sub> No

P7. Does anyone do hobbies or crafts in the home?

- A** <sub>1</sub> Yes  Specify \_\_\_\_\_  
<sub>2</sub> No

P8. Are there members of the household who work with hazardous materials on the job? (such as asbestos, batteries, lead, mercury, paint or pesticides).

- A** <sub>1</sub> Yes <sub>2</sub> No  Skip to P9 <sub>9</sub> Don't know  Skip to P9

P8a. Before coming home, do they ?

P8a. Change clothes.... <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

P8b. Change shoes ..... <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

P8c. Shower..... <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

P8d. Are their work clothes laundered separately from the family wash?

<sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

**Interviewer: for this questionnaire, the methods of getting information are:**  
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P9. Do you ever store household chemicals in containers that are different from the  
**A + O** original container without clearly labeling it?

<sub>1</sub> Yes <sub>2</sub> No

P10. Do you use candles or incense?

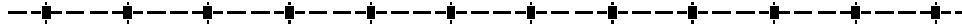
**A + O** <sub>1</sub> Yes <sub>2</sub> No

P10a. ►► If yes, do you use scented or unscented candles?

**A + O** <sub>1</sub> Scented (including incense) <sub>2</sub> Unscented <sub>9</sub> Don't know

P10b. ►► If yes, how often do you use candles/incense?

**A + O** <sub>1</sub> At least weekly  
<sub>2</sub> At least monthly  
<sub>3</sub> At least yearly  
<sub>4</sub> Never  
<sub>9</sub> Don't know



**Q. SAFETY**

Q1. Is lighting adequate for safety for the following places?

	Yes	No, no light fixture	No, light bulbs burned out	Not applicable
<b>O</b> Hallway	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>
Staircase	<input checked="" type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input checked="" type="checkbox"/> <sub>9</sub>
Porch/front door	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>
Walkway to house	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>9</sub>

Q2. Are the following structures in poor or deteriorating condition in any area of the home, inside or outside?

- A + O** Stairs <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Not applicable
- Railings <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Not applicable
- Porches and balconies <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Not applicable

Q3. Is there a working smoke detector on each floor in your home?

*(test detector by pushing test button)*

- A + O** <sub>1</sub> Yes
- <sub>2</sub> No - battery dead
- <sub>3</sub> No - no detector or broken
- <sub>8</sub> Can't test
- <sub>9</sub> Don't know

Q4. Is there a poison center number on or near the phone?

- A + O** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

Q5. Is there Syrup of Ipecac in the home?

- A + O** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

Q6. In case of fire do you have at least 2 ways to get out of your home? *(ways include a fire escape, exit door, balcony, window you can crawl through, or stairs from a public hall).*

- A+ O** <sub>1</sub> Yes <sub>2</sub> No <sub>9</sub> Don't know

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Q7. Are any firearms now kept in or around your home? Include those kept in a garage, outdoor storage area, car, truck, or other motor vehicle.

- A + O**    <sub>1</sub> Yes ▶▶ Ask Q7a & Q7b below.  
<sub>2</sub> No    ▶ Skip to end.  
<sub>9</sub> Don't know    ▶ Skip to end.

Q7a. Are any kept loaded?

- A + O**    <sub>1</sub> Yes    <sub>2</sub> No    <sub>9</sub> Don't know/refused

Q7b. Are any kept unlocked?

- A + O**    <sub>1</sub> Yes    <sub>2</sub> No    <sub>9</sub> Don't know/refused

**Thank you very much for allowing me walk though your home and for answering these questions.**

**TIME AT THE END OF THE INTERVIEW:** \_\_\_\_:\_\_\_\_  AM  PM