Thinking About Your Surroundings
Veteran Tool for the "Surroundings" Area of Self-Care

This Whole Health tool is designed to help you explore the many ways your surroundings affect your health. Your clinical team can help you complete it, if needed. There are five sections, and each is one-page long. Each section focuses on a different area you could consider working on:

1. Home
2. Work
3. Toxins
4. Senses
5. Emotions

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

Some questions to think about as you fill out this form:

- If you do not have a job, but you still have things you work on each day (like child care or volunteering) answer the questions in the Work section about those things.
- What is going well for you with your surroundings?
- Do any feelings come up for you when you answer different questions?
- Is there one thing you could change?
- Who could help you with the things you would like to change? If it involves finding resources available at your VA or in the community, it might help to talk with a social worker.

1. Home

- Do you have a place to live? ☐ 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
- Do you own your home or rent it? ☐ 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
- Do you live with other people? ☐No ☐Yes If so, whom?_____
- Have you ever fallen at home? ☐No ☐Yes
- Do you have concerns about how clean your home is? ☐ No ☐ Yes
- Do collect anything? ☐ 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*

<u>Do you currently live by</u>:

- Heavy traffic? ☐No ☐ Yes
- A farm? ☐No ☐ Yes
- Polluted water? ☐No ☐ Yes
- An industrial plant? ☐No ☐ Yes
- Other hazards? ☐No ☐ Yes
- A park/green space? ☐No ☐ Yes

<u>At home do you have</u>:

- Insect pests (e.g. bedbugs, roaches)? ☐No ☐Yes
- Guns? ☐No ☐Yes
- Smoke detectors? ☐No ☐Yes
- Carbon monoxide detectors? ☐No ☐Yes
- Good drinking water? ☐No ☐Yes
- Carpets? ☐No ☐Yes
- Air conditioning? ☐No ☐Yes

2. Work

- Do you have a job outside the home? ☐ No ☐ Yes
- Have you ever been unemployed? ☐ No ☐ Yes
- Have you ever been on disability? ☐ No ☐ Yes
- Do you do volunteer work? ☐ No ☐ Yes
- Do you work from your home? ☐ No ☐ Yes
- Are you retired? ☐ No ☐ Yes

<u>If you are employed</u>:

- Where do you work? _____

- What is your job title? _____

- On a scale of 1 to 5, how much 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
- Are you exposed to excess noise at work? ☐ No ☐ Yes
- How many breaks do 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
- Do you like your supervisor/boss? ☐No ☐Yes
- Do you like your coworkers? ☐No ☐Yes

- How would you describe your **work** environment?
  - Noise Level ☐Too much ☐Moderate ☐Little
  - Lighting Level ☐Too dim ☐Too bright ☐OK
  - Temperature ☐Too hot ☐Too cold ☐Too variable ☐OK
  - Air Movement ☐Drafty ☐Stuffy ☐OK
  - Humidity ☐Too moist ☐Too dry ☐OK
  - Bad smells ☐Too many ☐Moderate ☐OK
  - Overall Comfort ☐Poor ☐Somewhat OK ☐OK

3. Toxins

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
- Are there 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.

_____

_____

_____

_____

_____

_____

4. Senses

How would you rate the following for your living space?

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 ☐OK
- How is the air movement? ☐Drafty ☐Stuffy ☐OK
- How is the temperature? ☐Too hot ☐Too cold ☐Changes too much ☐OK

Light and Color

- How is the overall light level in your living space? ☐Too dim ☐Too bright ☐OK
- Do you ever find that low light levels affect your mood? ☐No ☐Yes
- Do you like the colors in your space? ☐No ☐Yes

Sound

- How is the noise in your living space? ☐Too much ☐No concerns
- 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

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

5. Emotions

- How much of the time are you happy?

1	2	3	4	5
Never	*Once a month*	*Once a Week*	*Once a Day*	*Most of the Time*

- 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 hurt in other ways by someone you care about? ☐No ☐Yes
- Have you been hit, kicked, punched, choked, or hurt other ways by anyone else? ☐No ☐Yes
- Is anyone emotionally abusive to you (do they try to hurt your feelings)? ☐No ☐Yes
- Beside your health care team, do you have people in your life who you can talk to 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 or watching TV)? ☐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
- Does the news stress you out? ☐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 spend on hobbies in a given week? _____

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