SATISFACTION STUDY: Tenants/Occupants

OBJECTIVE: review occupant’s habits and to gain insight into how they respond to their home environment.

CONTENTS:

A. Personal Information
B. Measurements in the Home (Temperature, Relative Humidity, CO₂ levels)
C. Initial Observations
D. Habits at Home
E. Room Temperature
F. Access to Sunlight
G. Windows
H. Ventilation
I. Humidity
J. Acoustic Insulation
K. Changes to Home
L. Perceived Stress
M. Positive and Negative Affectivity
N. Personal Well-Being & Conditions

Date: _______ Time: _______ Temperature/weather: ____________________

Floorplan (sketch)

A. PERSONAL INFORMATION
1. Name: ________________________________  2. Gender:  F | M

3. Address: ________________________________  4. Age: ____________

5. Housing Type: ________________________________  6. No. of Rooms: ______

7. Work Status: employed | unemployed | student | retired | other: ______________

8. Duration of stay: ________________  9. No. of occupants: ________________

9. Do you require special needs services? ________________

10. If so, what are they? ________________

B. MEASUREMENTS IN THE HOME

<table>
<thead>
<tr>
<th></th>
<th>Living Room</th>
<th>Kitchen</th>
<th>Bathroom</th>
<th>Bedroom 1</th>
<th>Bedroom 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEMP (°C)</td>
<td>°C</td>
<td>°C</td>
<td>°C</td>
<td>°C</td>
<td>°C</td>
</tr>
<tr>
<td>RH (%)</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>CO₂ (%)</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
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</tbody>
</table>

- Additional Rooms/Spaces

|          |             |           |           |           |           |
|----------|-------------|-----------|-----------|-----------|
| TEMP (°C) | °C          | °C        | °C        | °C        | °C        |
| RH (%)   | %           | %         | %         | %         | %         |
| CO₂ (%)  | %           | %         | %         | %         | %         |

C. INITIAL OBSERVATIONS (e.g. air quality, stuffiness, temperature, lighting, sunlight, etc.)
D. HABITS AT HOME

1. On average, how many hours do you spend at home?

   Weekdays: ________ hrs
   Weekends: ________ hrs

2. Describe your daily routine in the house. (audio recorded – requires consent)
   Weekdays: ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   Weekends: ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

   • Habits to observe: laundry, washroom, kitchen, cleaning, temperature/heating, windows, use of appliances, garden, balcony space, pets, lighting, etc.

E. ROOM TEMPERATURE

1. Which rooms/spaces have heating? ________________________________

2. What type of heating do you use?
   Central Heating: Y | N       Other: ______________       Additional: ______________

3. Which months do you use heating?
   J  F  M  A  M  J  J  A  S  O  N  D
   Bold- Fall/Winter
   Underline- Spring

4. What time of day do you have the heating on?
   Morning: ____________________________       Afternoon: ____________________________
   ____________________________
   Evening: ____________________________       Night: ____________________________
   ____________________________

5. On average, at what level do you set the heater (heat emitter) at for each room/space?
6. On average, at what temperature do you set the main thermostat at? ______ °C

7. Why do you set the thermostat and heater at these settings for each room?

    __________________________
    __________________________
    __________________________

F. ACCESS TO SUNLIGHT

1. Which rooms have windows? __________________________

2. What is the orientation of each of your windows?

    Kitchen: __________________________
    Bathroom: __________________________
    Living Room: __________________________
    Bedrooms: __________________________
    Conservatory: __________________________
    Other: __________________________

3. From a scale of one to five, rate the importance of access to sunlight in your home?

    UNIMPORTANT 1 2 3 4 5 VERY IMPORTANT

4. Describe the aspects in which natural sunlight benefits your lifestyle? (e.g. solar heat gains, cost effectiveness, ambience, source of motivation, etc.)

    __________________________
    __________________________
    __________________________

5. How does natural sunlight affect your mood?

    __________________________
    __________________________
    __________________________

6. How does sunlight affect your habits in the home? (e.g. activity level)

    __________________________
    __________________________
    __________________________
7. From a scale of one to five, rate the importance of an outdoor space with good access to sunlight?

<table>
<thead>
<tr>
<th>Importance</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>VERY IMPORTANT</th>
</tr>
</thead>
</table>

8. From a scale of one to five, rate the importance of private outdoor?

<table>
<thead>
<tr>
<th>Importance</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>VERY IMPORTANT</th>
</tr>
</thead>
</table>

9. From a scale of one to five, rate the importance of communal outdoor?

<table>
<thead>
<tr>
<th>Importance</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>VERY IMPORTANT</th>
</tr>
</thead>
</table>

G. WINDOWS

1. On a daily average while the heating is ON, how often do you open the windows in each room? Kitchen: __________________________
   Bathroom: __________________________
   Living Room: __________________________
   Bedrooms: __________________________

2. Why do you choose to open the windows for this duration of time? __________________________
   __________________________

3. Do you use the trickle or other window/wall vents? Y | N (go to #6) | no vents

4. How often do you open/close the trickle or window vents? __________________________
   __________________________

5. What are your reasons to manage the trickle vents for these periods? __________________________
   __________________________

6. If you DO NOT use the trickle vents, what are the reasons for this?
   Height/inaccessibility: Y | N
   Inconvenient/hassle: Y | N
   Obstruction (i.e. curtains/blinds): Y | N
   Unsure how to use: Y | N
   Other: __________________________

H. VENTILATION

1. Do you have extract fans in the home? Y | N
2. If YES, in which rooms do you have extract fans? ________________________

3. Which fans do you use on a regular basis? ________________________

4. (a) Which fans are automatically triggered and which are manually switched-on? _____

(b) If any, which automatic fans are humidistat-controlled and which use a timer? _____

5. What are your reasons for using these extract fans? ________________________

6. If you have disabled any extract fans, which ones are they? ________________________

7. Why have you disabled these fans? ________________________

8. Do you have a passive stack ventilation system? Y | N

9. If any, what other passive ventilation systems do you have and use (i.e. hallway, wall or room vents)? ________________________

10. Do you require a dehumidifier? Y | N

11. If YES, how often do you use it? ________________________

12. What are your reasons for using the dehumidifier? ________________________
I. HUMIDITY

1. How do you do your laundry?
   - Washing Machine
   - Hand-wash
   - Launderette
   - Other: ________________

   Combination: ____________________________

2. How often do you do your laundry? ________________________________

3. (a) If you **DO own a washer**, does it have a tumble dryer?   Y | N (go to #7)  **Model #:**

   (b) Or a separate tumble dryer?      Y | N

4. Where is the washer/tumble dryer located?
   - Kitchen
   - Utility room
   - Other: ________________

5. How often do you use the tumble dryer? ________________________________

6. (a) How is your tumble dryer vented or plumbed in?
   - Purpose built duct to outside
   - Flexible hose system
   - No ventilation system
   - Other: ____________________________

   (b) If dryer has **no vented system and is not plumbed in (condenser type)**, do you feel that the **heat emitted is an added benefit**?   Y | N

7. If you **DO NOT own a tumble dryer**, how do you dry your clothes?
   - Hang dry outside
   - Hang dry indoors (clothes horse/closet space)
   - Dry on radiators
   - Other: ____________________________

8. (a) Have you noticed any surface condensation on the windows?   Y | N

   (b) If so, when does this usually occur? ________________________________
9. (a) Have you noticed any mould or mildew on your walls/surfaces?  Y | N

(b) If so, which walls/surfaces have mould or mildew? ________________________________

(c) Is there mildew on your clothing (i.e. in wardrobes or drawers)?  Y | N

J. ACOUSTIC INSULATION (title -- revision needed ?)

1. Can you hear your neighbours from your flat (beside, below or neighbouring flats)?  Y | N

2. If YES, can you describe the circumstances in which you can hear your neighbours?
   - *Time of day and duration of noise, age group, activity and cause of noise, etc.*

3. On a scale of one to five, please rate the frequency of noise you can hear from your flat.
   NEVER 1 2 3 4 5 VERY OFTEN

4. On a scale of one to five, please rate the degree of disturbance the noise has caused you.
   NEVER 1 2 3 4 5 VERY OFTEN

K. CHANGES TO HOME

1. Describe some things you would like improved with the design of your home including external space (private or communal)?

   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
2. How would these changes benefit your lifestyle?

3. If any, what are some complaints you have with your housing conditions at the moment?

L. PERCEIVED STRESS SCALE

On a scale of one to five, rate the degree to which you felt the following in the past month in your house:

<table>
<thead>
<tr>
<th></th>
<th>NEVER</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>VERY OFTEN</th>
</tr>
</thead>
</table>
1. How often have you been upset because of something that happened unexpectedly in the house? ______

2. How often have you felt that you were unable to control the important things in your life because of matters with your home? ______

3. How often have you felt nervous and stressed in your house? ______

4. How often have you felt that things were going your way in the house? ______

5. How often have you found that you could not cope with all the things you had to do in the house? ______
6. How often have you been angered because of things that happened beyond your control in
the house? _________

7. How often have you been able to control the way that you spend your time in and out of the
house? ______

8. How often have you felt difficulties were piling up so high that you could not overcome them
in the house? _________

M. POSITIVE AND NEGATIVE AFFECTIVITY SCALES

On a scale of one to five, please rate the extent to which you have felt these emotions listed
below in the past few weeks.

NEVER  1  2  3  4  5  VERY OFTEN

Enthusiastic       Proud
Irritable         Ashamed
Alert/Attentive    Upset
Nervous           Scared/Afraid

N. PERSONAL WELL-BEING

On a scale of one to five, please rate the frequency of occurrence of these ailments over the
past 3 months.

NONE  1  2  3  4  5  VERY OFTEN

1. Inability to get to sleep or stay asleep. _________

2. Headaches and pains in your head. _________

3. Indigestion or sickness. ______

4. Feeling unaccountably tired or exhausted. _________

5. Tendency to eat, drink or smoke more than usual. _________
6. Shortness of breath or feeling dizzy. ______

7. Decrease in appetite. ______

8. Muscles trembling (e.g. eye twitch). ______

9. Pricking sensations in parts of your body. ______

10. Feeling as though you don’t want to get up in the morning. ______

11. Tendency to sweat or a feeling of your heart beating hard. ______

12. Dryness of eyes. ______

13. Itchy/watery eyes. ______

14. Blocked/stuffy nose. ______

15. Runny nose. ______

16. Lethargy and/or tiredness. ______

17. Dry, itching and irritated skin. ______

18. Do you think these symptoms are related to your living conditions? Y | N

19. If YES, please describe what you think may be causing these ailments.

20. (a) Do you maintain a regular diet on a daily basis? Y | N
(b) If NO, why not? ____________________________________________

21. (a) Are you taking any drugs/prescription at the moment? Y | N
(b) If YES, what are you taking and why? ____________________________

22. (a) Are you a smoker? Y | N
(b) If YES, how many packs do you smoke per day? __________

23. What is your average weekly alcohol consumption? _______ Units/week
(1 unit = ½ pint of beer, 1 glass of wine, 1 measure of spirits, etc.)

24. (a) Do you own pets? Y | N
(b) If YES, what pets do you have and how many? ____________________________