



Supporting you on your driving journey

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Driving Self-Assessment

This self-assessment is not a formal assessment, but a method that can help you to evaluate your own driving and identify any safety issues. It is for you to complete on your own or with your loved one. The questions should be answered as objectively as possible.

Driving history and behaviors

Did you get lost while driving in a relatively familiar environment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have difficulty operating the controls (e.g. pedals, indicators, clutch) of your vehicle?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you think you are slower than you used to be when reacting to driving situations?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you had any close calls, scrapes or accidents while driving?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you get easily flustered/anxious in heavy/unanticipated traffic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do people hoot at you while you drive?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you get nervous at intersections because there is so much to watch out for?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do other cars appear from nowhere?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you find it difficult to change lanes?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you stopped driving in certain circumstances e.g. night driving, peak hour traffic, highways?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have your family/friends expressed concern about your driving?	Yes <input type="checkbox"/> No <input type="checkbox"/>
How would you rate your own driving? 1 - Excellent 2 - Good 3 - Fair 4 - Not so good anymore 5 - I should consider driving retirement/My family has suggested that I stop driving	

Vision

Do you find it harder to read road signs than you are used to?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you struggle with glare from oncoming headlights?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have trouble seeing/noticing pedestrians or cyclists?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you find it difficult to change your visual focus when looking ahead in the distance and then close-up at the instrument panels in the car?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have more trouble than before in judging distances with other cars and how fast they are moving?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you hit the curb by mistake while turning right or left, or make your turns too wide or too narrow?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Physical mobility

Do you find it more difficult to turn your head to see over your shoulder than you used to?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you struggle to grip and turn the steering wheel more than you used to?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you struggle to feel where the pedals are with your feet?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have difficulty in using the foot pedals?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you struggle to turn the keys in the ignition or put your safety belt on?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Attention and focus

Do you have trouble concentrating when driving?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you feel more tired after, or while driving than you used to?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you feel that your reactions are slower or that you take longer to respond to traffic situations?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Judgement and making decisions

Do you find it more challenging to drive on high speed roads, or in busy traffic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you find it more difficult to decide when it is safe to go and when to wait at intersections or turns?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you struggle to make fast decisions and act appropriately to the traffic conditions?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you drive slower than other cars, even when there is little traffic?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Emotional

Do you feel anxious when you are driving to the point where you feel it affects your driving?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have less confidence when driving and worry about being in an accident?	Yes <input type="checkbox"/> No <input type="checkbox"/>

If you answered yes to any of the questions and feel that certain changes affect your driving, you may consider the following:

- ✔ A comprehensive driving evaluation with an occupational therapist.
- ✔ Changing how and where you drive - see handout on **Tips for safe driving.**
- ✔ Car adaptations - sometimes small changes can make a big difference.
- ✔ Driving retirement and transportation planning. See handout on **transportation planning**

Vision

Regular check-ups with your ophthalmologist are recommended for early diagnosis and treatment of possible eye conditions. Certain neurological conditions may affect vision and will need further evaluation and management. Your occupational therapist can provide a vision screening and assess for neurological deficits that may impact driving. Certain adaptations to your car may assist where there are existing visual problems.

Physical mobility

Exercising and stretching is important to maintain good strength and flexibility for driving. Certain adaptations can be made to your car to make driving a little easier and less painful. Your Occupational therapist can give you advice on what may be helpful.

Tiredness/fatigue

Lack of sufficient sleep, medications or medical conditions causing fatigue can decrease your concentration. Consult your doctor if you are worried about the effects of your medication. Monitor yourself and do not drive when fatigued. People with Parkinson's disease may have periods when their medication wears off and should be aware if/when this happens.

Anxiety

Being very anxious may impair your ability to concentrate which can lead to errors while driving. Consider the reasons behind your anxiety.

Medical self-assessment

Please answer by ticking yes or no or unsure to the following questions

Have you had a blackout in the last 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have a history of heart problems (<i>e.g. heart failure, bypass, valve replacement</i>) or a heart attack?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Have you had a stroke/TIA?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have diabetes that requires medication?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have severe arthritis or stiffness in joints that limits movement?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have a neurological condition that is progressive (<i>(e.g. Parkinson's disease, Multiple Sclerosis, Dementia, Alzheimer's disease)</i>)	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have any other neurological conditions (<i>e.g. Epilepsy, brain tumour, hydrocephalus</i>)	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have a mental health condition (<i>e.g. Anxiety, depression, schizophrenia</i>)	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have a chronic sleep disorder (<i>e.g. sleep apnoea, narcolepsy</i>)	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have an alcohol or drug disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you have any eye/vision disorders (<i>e.g. cataracts, glaucoma, macular degeneration, diabetic retinopathy</i>)	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>
Do you take any medication that may affect your driving? (<i>e.g. anti-histamines, medication that causes drowsiness</i>)	Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/>

If you have answered yes/unsure to any of these questions and have not consulted your doctor about your driving with these medical conditions, you are advised make an appointment and take this form with you.