ELDER ABUSE SCALE

Patient's Name: _____ Date: _____

Instructions: Circle the best answer for how you felt over the last 12 months.

No.	Question	Answer
# 1	Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals?	Yes / No
# 2	Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	Yes / No
# 3	Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes / No
# 4	Has anyone tried to force you to sign papers or to use your money against your will?	
# 5	Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes / No