FUNCTIONAL ASSESSMENT: Name_____

Please circle the response that best matches your ability to do these tasks.

A. Ability to use telephone

1. Operates telephone on own initiative; looks up and dials numbers, etc.
2. Dials a few well-known numbers
3. Answere telephone but does not dial
4. Does not use telephone at all

B. Shopping

1. Takes care of all shopping needs independently
2. Shops independently for small purchases
3. Needs to be accompanied on any shoppping trip.
4. Completely unable to shop

C. Food Preparation

1. Plans, prepares and serves adequate independently
2. Prepares adequate meals if supplied with ingredients
3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet
4. Needs to have meals prepared & served

D. Housekeeping

1. Maintains house alone or with occasional assistance
2. Performs light daily tasks such as dishwashing, bed making
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness
4. Needs help with all home maintenance tasks
5. Does not participate in any housekeeping tasks.

E. Laundry

1. Does personal laundry completely
2. Launders small items; ie. stockings
3. All laundry must be done by others

F. Ability to Handle Finances

1. Manages matters independently,
2. Manages day to day purchases, but needs help with banking, major purchases
3. Incapable of handling money

G. Mode of Transportation

1. Travels independently on public transportation or drives car
2. Travels independently using public transportation, but does not drive car
3. Travels using public transport but with assist of another
4. Does not travel at all or via medical transport.

H. Responsibility for own Medications

1. Is responsible for taking medications in correct dosages at correct time
2. Is responsible for taking medications if someone prepares in advance
3. Is not capable of dispensing own medications.

I. Toilet

1. Independent toileting skills
2. Needs assistive devices
3. Needs assist of another in bathroom
4. Cannot use the bathroom facilities
5. No incontinence of bowel/bladder
7. Occasional incontinence
8. Incontinence more than once/week
9. No control of bowel/bladder

J. Feeding

1. Feeds self without assistance
2. Eats with minimal assist ie: cutting
3. Untidy & needs moderate assist
4. Requires complete assist to eat

K. Dressing

1. Dresses & undresses self
2. Needs minimal assist (socks,buttons)
3. Needs moderate assist (tops/bottoms)
4. Unable to assist with dressing skills

L. (Grooming (hair, nails,face, clothing)

1. Grooms well without assistance
2. Requires some assistance (shaving)
3. Requires moderate assistance
4. Totally dependent in grooming skills

M. Physical Ambulation

1. Walks independently outside of home
2. Walks independently around home
3. Walks with assistance of: another person, cane, or walker.
4. Can propel self in wheelchair/scooter
5. Requires assistance in wheelchair
6. Bedridden more than half the time

N. Bathing

1. Bathes self in tub or shower
2. Bathes self, but needs help in/out of shower or tub
3. Washes hands/face, but needs assist for rest of body
4. Totally dependent in bathing skills

Date completed: _____
Completed by: _____
Total Points: _____

<21: Self Sufficient
21-32: Requires some type of assistance
>33 : Requires live-in assistance or Nursing home care

Speech:

1. Good- easily understood
2. Stutter
3. Aphasia (inappropriate word usage)
4. Dysphasia (difficulty w/speech)
5. Mute

Hearing:

1. Excellent- no problem
2. Good- some problems in noisy areas
3. Poor- difficulty with one on one conversation
4. Deaf- Cannot hear at all
5. Wears hearing aides

Vision:

1, Excellent (20/20)
2. Wears glasses/contacts
3. Impaired: Cataracts
4. Impaired: Glaucoma
5. Impaired: Macular Degeneration
6. Impaired: Retinopathy