Individual's Name _____ Telephone _____

Current Address _____

_____

Secondary Contact _____ Telephone _____

a. Functional Limitations

Personal Activities of Daily Living

1. Ambulation
   - _____ a. Independent with or without assistive device
   - _____ b. Walks with difficulty, with or without assistive device
   - _____ c. Walks with continuous physical support (railings or help of another person)
   - _____ d. Bed to chair (e.g., trunk control)
   - _____ e. Bedfast

   If an assistive device is used, indicate type: _____

2. Transfer
   - _____ a. No Assistance
   - _____ b. Equipment only
   - _____ c. Supervision only
   - _____ d. Requires transfer with or without equipment
   - _____ e. Bedfast

   Comments: _____

3. Wheelchair use
   - _____ a. Independent with or without powered chair
   - _____ b. Assistance in difficult maneuvering
   - _____ c. Wheels a few feet
   - _____ d. Unable

   Comments: _____

4. Bladder incontinence
   - _____ a. Continent
   - _____ b. Rarely
   - _____ c. Occasional (once a week or less)
   - _____ d. Frequent- up to once a day
   - _____ e. Total incontinence
   - _____ f. Catheter-indwelling (self-care should be assessed on an individual basis)

   Comments: _____

5. Bowel Incontinence

_____ a. Continent
_____ b. Rarely
_____ c. Frequent (once a week or more)
_____ d. Total incontinence
_____ e. Ostomy (self-care should be assessed on an individual basis)

Comments: _____

6. Bathing

_____ a. No assistance
_____ b. Supervision
_____ c. Assistance in shower or tub
_____ d. Is bathed in shower or tub
_____ e. Is bathed-bed bath procedure

Comments: _____

7. Dressing

_____ a. Dresses self
_____ b. Minor assistance
_____ c. Partial help-completes half dressing
_____ d. Has to be dressed

Comments: _____

8. Grooming

_____ a. No assistance
_____ b. Needs occasional minor assistance (help washing hair, trimming toenails)
_____ c. Needs daily minor assistance
_____ d. Needs total assistance

Comments: _____

9. Toileting

_____ a. No assistance
_____ b. Assistance to/ from and transfer
_____ c. Help with clothes, personal hygiene
_____ d. Toileting at bedside, commode

Comments: _____

Daily Habits

Alcohol

Own use: _____

Tolerance of others: _____

Tobacco

Tolerance of others: _____

Usual waking hours: _____

Customary pastimes: _____

Strong dislikes: _____

Eating Habits

Dietary Restrictions

_____ Salt Free

_____ Sugar Free

Allergies

Food preferences: _____

Food aversions: _____

Life Experiences

1. Family
2. Informal Social Network (family, friends)
3. Education
4. Work
5. Religion _____ Active

   Involvement? _____
6. Ethnicity, if important to the person:
7. Prior living situations:

Applicant's statement of own needs, desires, fears, expectations, etc.

_____

_____

_____

_____

_____

_____

Persons to see for further information and/ or verification.

Name: _____

Address: _____

City/Town: _____

Phone: ( ) _____

Name: _____

Address: _____

City/Town: _____

Phone: ( ) _____

_____
Assessment completed by

_____
Date