

Patients Name: _____ Age: _____ Date: _____

In order for us to assess your symptoms, we need to know if any of the following functions are affected by your condition(s).

In many cases your insurance company may only cover treatments that will help to improve your function. Please check off all functions that are limited and feel free to write in any others that may not be listed.

	Normal	Difficult	Other	Describe
Getting on/off from chair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting in and out of car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Laying down in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting out of bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing/showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking distances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Housecleaning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Household chores-trash/laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carrying packages	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing up stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Going down stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gardening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Putting on shoes or socks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Foot care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gripping with hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Carrying /lifting objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pushing/pulling objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Personal relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance while standing/walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Typing/computer/writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hair care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sitting long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing long periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

I live Alone I am a caretaker