FUNCTIONAL ASSESSMENT **Patient Name:**_____

Please complete this questionnaire reporting your current status.

1. Do you need assistance with any activities required for taking care of yourself? Examples would include dressing, bathing, writing letters, eating, walking or going up and down stairs. If yes, please describe the activities and the assistance you receive.

2. Do you need assistance with other routine daily activities, such as cooking, driving, gardening, vacuuming, doing the laundry, buying groceries, or other household cleaning tasks? If yes, please describe the activities and the assistance you receive.

3. Are you currently working? Yes/No If yes, how many hours per day are you working? If yes, do you require assistance with any of your job tasks? If assistance is required, please describe the type of assistance needed.

4. Since your last visit at this clinic, would you say that your needs for assistance with work or home activities has:
   a. Increased
   b. Decreased
   c. Remained the Same

   If your need for assistance has increased, describe any reasons that you believe have caused the need for more assistance. Examples might include difficulty sleeping, increased pain, new physical injuries or problems, difficulties with your home or work situation, increasing physical fatigue when performing specific tasks, etc.

Thank you for your patience in completing this form. Please discuss your answers with your physician so that any adjustments which may be necessary to your treatment plan can be fully discussed.