

Daily Activities

Your Name: _____ Date: _____

Social Security No. _____ Helper: _____

A. Are You Working

1. Are you working? Yes No
2. If not, could you work all day, five days a week, year round? Yes No
3. Did your health stop you from working? Yes No
4. If so, when did you stop being able to work(month, day, year)? _____

B. Activities of Daily Living

1. **Typical Month.** Please state how many good, fair, and bad days you have each month. (Consider a month to be 30 continuous days.)

Good Days -- You do well and complete all living and home care activities.

Days a month: _____

Fair Days -- You function with serious difficulty and fail to complete some living and home care activities.

Days a month: _____

Bad Days -- You function very poorly and fail to complete most living and home care activities

Days a month: _____

Explain why you do worse on bad/fair days.

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2. Are there days when you don't go out because of your health?

- Yes If yes, how many days a month does your health keep you in?
 No

Explain what keeps you from going out.

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3. Compared with a year ago, are you functioning:

- Better?
 - Worse?
 - About the same? Please explain.
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4. Caring For Yourself

Personal Needs. Do you have any serious difficulty taking care of your personal needs, like the following?

- Bathing
- Shaving
- Hair Care
- Dressing
- Eating
- Using the Toilet
- Getting to the Toilet in Time
- Using Stairs
- Holding onto Objects
- Using the Telephone
- Doing Things You Start
- Taking Medicines at the Right Time and in the Dose Prescribed
- Reading and Following Instructions
- Other?

If **yes**, Please describe.

Comments

Applicant Statement

The information listed above is complete and correct to the best of my knowledge.

Date _____ Signature of Applicant _____