

Name:

DOB:

Date:

Health Assessment Questionnaire

Please place an "x" in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
<u>DRESSING & GROOMING</u>				
Are you able to:				
Dress yourself, including shoelaces and buttons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>ARISING</u>				
Are you able to:				
Stand up from a straight chair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>EATING</u>				
Are you able to:				
Cut your own meat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lift a full cup or glass to your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open a new milk carton?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>WALKING</u>				
Are you able to:				
Walk outdoors on flat ground?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb up five steps?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

<input type="checkbox"/> Devices used for Dressing (button hook, zipper pull, etc.)	<input type="checkbox"/> Built up or special utensils	<input type="checkbox"/> Crutches
<input type="checkbox"/> Special or built up chair	<input type="checkbox"/> Cane	<input type="checkbox"/> Wheelchair
	<input type="checkbox"/> Walker	

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

<input type="checkbox"/> Dressing and grooming	<input type="checkbox"/> Arising	<input type="checkbox"/> Eating	<input type="checkbox"/> Walking
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Please place an “x” in the box which best describes your abilities OVER THE PAST WEEK:

	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
<u>HYGIENE</u>				
Are you able to:				
Wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take a tub bath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get on and off the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>REACH</u>				
Are you able to:				
Reach and get down a 5 pound object (such as a bag of sugar) from above your head?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend down to pick up clothing from the floor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>GRIP</u>				
Are you able to:				
Open car doors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open previously opened jars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turn faucets on and off?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<u>ACTIVITIES</u>				
Are you able to:				
Run errands and shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get in and out of a car?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do chores such as vacuuming or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check any AIDS OR DEVICES that you usually use for any of the above activities:

<input type="checkbox"/> Raised toilet seat	<input type="checkbox"/> Bathtub bar	<input type="checkbox"/> Long-handled appliances for reach
<input type="checkbox"/> Bathtub seat	<input type="checkbox"/> Long-handled appliances in bathroom	<input type="checkbox"/> Jar opener (for jars previously opened)

Please check any categories for which you usually need HELP FROM ANOTHER PERSON:

<input type="checkbox"/> Hygiene	<input type="checkbox"/> Reach	<input type="checkbox"/> Gripping and opening things	<input type="checkbox"/> Errands and chores
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Your ACTIVITIES: To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

COMPLETELY	MOSTLY	MODERATELY	A LITTLE	NOT AT ALL
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Your PAIN: How much pain have you had IN THE PAST WEEK?
On a scale of 0 to 100 (where zero represents “no pain” and 100 represents “severe pain”), please record the number below.

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Your HEALTH: Please rate how well you are doing on a scale of 0 to 100 (0 represents “very well” and 100 represents “very poor” health), please record the number below.

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