FUNCTIONAL ASSESSMENT

NAME	CONTINUING CARE NO.	DATE YYYY	MM	DD

DIAGNOSIS

MEDICAL HISTORY

SOCIAL HISTORY

1. FUNCTION

Speech ______________________

Hearing ______________________

Vision ______________________

Write / Type ______________________

Telephone ______________________

Psychosocial Status ______________________

Orientation / Memory ______________________

Perception / Comprehension ______________________

Insight / Motivation ______________________

Home Accessibility ______________________

KEY **# - Number of Problem** **P - Problem** **NP - No Problem** **NA - Not Assessed**

2. SELF CARE – A.D.L.

		#	P	NP	NA	COMMENTS
FEEDING	KNIFE - FORK SPOON - DRINK					
DRESSING	UPPER					
	LOWER					
HYGIENE / GROOMING	HAIR - SHAVE MAKEUP - TEETH					
TOILET	ADJUST CLOTHING					
	CLEAN SELF					
BLADDER / BOWELS						
BATHING / SHOWER						

3. MOBILITY

		#	P	NP	NA	
BED	TURN OVER / TO SITTING					
TRANSFERS	BED					
	WHEELCHAIR / CHAIR					
	TOILET					
	BATH					
	CAR					
AMBULATION	WEIGHT BEARING ALLOWED					
AID REQUIRED	GAIT AIDS					
	BRACE / PROSTHESIS					
TOLERANCE						
AMBULATION	INDOORS					
	OUTDOORS					
	STAIRS					

3. MOBILITY (cont'd.)		#	P	NP	NA	COMMENTS
WHEELCHAIR						
WHEELCHAIR MANAGEMENT	MOBILITY					
	SAFETY					
SEATING						

4. PHYSICAL STATUS		#	P	NP	NA	(FUNCTIONAL MOVEMENT – STRENGTH / R.O.M. – SENSATION)
UPPER LIMBS	RIGHT					
	LEFT					
LOWER LIMBS	RIGHT					
	LEFT					
SENSATION						
BALANCE	SITTING					
	STANDING					
POSITIONING / PRESSURE						
TRUNK						HEAD
						NECK
DEXTERITY	HAND ACTIVITY					

5. HOMEMAKING		#	P	NP	NA	COMMENTS
MEAL PREPARATION	SIMPLE					
	TOTAL					
	CLEAN UP					
HOMEMAKING	BEDS					
	LAUNDRY					
	CLEANING					
	SHOPPING					
	OTHER					
6. LEISURE / PRODUCTIVITY						
7. SAFETY AWARENESS / FIRE / APPLIANCES						

8. SERVICES NEEDED	YES	NO	COMMENTS
EQUIPMENT			
HOME SUPPORT WORKER			
MEALS ON WHEELS			

ADDITIONAL COMMENTS

SIGNATURE	DATE (YYYY MM DD)