ASSESSMENT OF ACTIVITIES OF DAILY LIVING

Client Name:	UCI number:	UMI number:	IME Number:

SELF-CARE	**Can the client perform the following without help:**			
	Yes, with ease	**Yes, with difficulty**	**No, some help required**	**No, totally dependent**
Feed / Drink	☐	☐	☐	☐
Dress Upper body	☐	☐	☐	☐
Dress Lower body	☐	☐	☐	☐
Put on braces / Prosthesis	☐	☐	☐	☐
Wash / Bathe	☐	☐	☐	☐
Perineum (at toilet)	☐	☐	☐	☐

SPHINCTER'S CONTROL	**Please confirm the client's level of sphincter's control:**			
	Complete	**Control with urgency**	**Occasional accidents**	**Frequent accidents**
Bladder Control	☐	☐	☐	☐
Bowel Control	☐	☐	☐	☐

MOBILITY / LOCOMOTION	**Can the client perform the following without help:**			
	Yes, with ease	**Yes, with difficulty**	**No, some help required**	**No, totally dependent**
Transfer bed	☐	☐	☐	☐
Transfer chair / Wheelchair	☐	☐	☐	☐
Transfer Toilet	☐	☐	☐	☐
Transfer Tub / Shower	☐	☐	☐	☐
Transfer Automobile	☐	☐	☐	☐
Walk 50 metres - Level	☐	☐	☐	☐
Stairs, Up / Down 1 floor	☐	☐	☐	☐
Walk Outdoors - 50 meters	☐	☐	☐	☐
Wheelchair - 50 meters	☐	☐	☐	☐

COMMUNICATION / SOCIAL COGNITION	**Please record the client's level of:**			
	Full	**Moderate**	**Minimal**	**Null**
Comprehension	☐	☐	☐	☐
Expression	☐	☐	☐	☐
Social Interaction	☐	☐	☐	☐
Memory	☐	☐	☐	☐

CONCLUSION	**Intact**	**Limited**	**Helper**	**Null**
Self-Care	☐	☐	☐	☐

RESIDENCE	**Own Home**	**Relative's Home**	**Personal care Home**	**Hospital**
Current	☐	☐	☐	☐
Other (specify):				
Time at above:	Years	Months		

Current Caregiver:	Relationship to client:

Name of Examining Physician

Signature of Examining Physician

Date (YYYY-MM-DD)