Medical Record # _____
Name _____
Age/DOB _____
Date _____

Functional Assessment
(65 years or older or disabled)

Needs assistance or has difficulty independently doing the following:

1. Bathing? Y/N
2. Getting to the bathroom? Y/N
3. Getting on or off the toilet seat? Y/N
4. Getting in/out of bathtub/shower? Y/N
5. Dressing? Y/N
6. Walking? Y/N
7. Needs assistive device? __cane __walker __wheelchair __Other
8. Grocery Shopping Y/N
9. Eating? Y/N
10. Opening containers/jars? Y/N
11. Cooking? Y/N
12. Do you sometimes forget about food cooking on the stove/ in the oven? Y/N
13. Getting in/out of bed? Y/N
14. Doing housecleaning/laundry? Y/N
15. Managing finances/bills? Y/N
16. Taking medications? Y/N
17. Reading? Y/N
18. Writing? Y/N
19. Using the telephone? Y/N

Comments:
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Intervention Plan:
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Interviewer Signature _____