

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**HEALTH ASSESSMENT QUESTIONNAIRE**

*Please select the response that best describes your ability over the PAST WEEK.*

	Without Difficulty	With some difficulty	With much difficulty	Unable to do
<b>DRESSING AND GROOMING:</b>				
Are you able to dress yourself, including shoelaces and buttons?				
Shampoo your hair?				
<b>ARISING:</b>				
Are you able to stand up from a straight chair?				
Get in and out of bed?				
<b>EATING:</b>				
Are you able to cut your own meat?				
Lift a full cup or glass to your mouth?				
Open a milk carton?				
<b>WALKING:</b>				
Are you able to walk outdoors on flat ground?				
Climb up five steps?				

*Please check any aids or devices you usually use for any of the above activities*

Devices used for dressing (button hook, zipper pull)	Built up or special utensils	Crutches
Special or built up chair	Cane	Wheelchair
	Walker	

*Please check any categories for which you usually need help from another person*

- Dressing and grooming
  Arising
  Eating
  Walking

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**HEALTH ASSESSMENT QUESTIONNAIRE (Continued)**

	Without Difficulty	With some difficulty	With much difficulty	Unable to do
<b>HYGIENE:</b>				
Are you able to wash and dry your body?				
Take a tub bath?				
Get on and off the toilet?				
<b>REACH:</b>				
Are you able to reach and get down a 5-pound object (such as a bag or sugar) from above your head?				
Bend down and pick up clothing from the floor?				
<b>GRIP:</b>				
Are you able to open car doors?				
Open previously opened jars?				
Turn faucets on and off?				
<b>ACTIVITIES:</b>				
Are you able to run errands and shop?				
Get in and out of a car?				
Do chores such as vacuuming or yard work?				

**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"/> Bath tub bar	<input type="checkbox"/> Long handled appliances for reach
<input type="checkbox"/> Bath tub 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**

- Hygiene     
  Reach     
  Gripping and opening things     
  Errands and chores

**-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

**-How much pain have you had in the past week? On a scale of 0 to 100 (where "0" represents no pain and "100" represents severe pain, please record the number here \_\_\_\_\_.**

*-Please rate how well you are doing on a scale of 0 to 100 (where "0" represents very well and 100 represents very poor health). Please record the number here \_\_\_\_\_.*