

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

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SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle Initial, Last)*

2. **SOCIAL SECURITY NUMBER**

3. **YOUR DAYTIME TELEPHONE NUMBER** *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

_____ Your Number Message Number None
Area Code Phone Number

4. a. Where do you live? *(Check one.)*

House Apartment Boarding House Nursing Home
 Shelter Group Home Other *(What?)* _____

b. With whom do you live? *(Check one.)*

Alone With Family With Friends
 Other *(Describe relationship.)* _____

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. How do your illnesses, injuries, or conditions limit your ability to work?

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? Yes No

If "YES," for whom do you care, and what do you do for them?

8. Do you take care of pets or other animals? Yes No

If "YES," what do you do for them?

9. Does anyone help you care for other people or animals? Yes No

If "YES," who helps, and what do they do to help?

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

11. Do the illnesses, injuries, or conditions affect your sleep? Yes No

If "YES," how?

12. **PERSONAL CARE** (Check here if **NO PROBLEM** with personal care.)

a. Explain how your illnesses, injuries, or conditions affect your ability to:

Dress _____

Bathe _____

Care for hair _____

Shave _____

Feed self _____

Use the toilet _____

Other _____

b. Do you need any special reminders to take care of personal needs and grooming?

Yes No

If "YES," what type of help or reminders are needed?

c. Do you need help or reminders taking medicine?

Yes No

If "YES," what kind of help do you need?

13. MEALS

a. Do you prepare your own meals?

Yes No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.)

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

How long does it take you? _____

Any changes in cooking habits since the illness, injuries, or conditions began?

b. If "No," explain why you cannot or do not prepare meals.

14. HOUSE AND YARD WORK

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.)

b. How much time does it take you, and how often do you do each of these things?

c. Do you need help or encouragement doing these things?

Yes No

If "YES," what help is needed?

d. If you don't do house or yard work, explain why not.

15. GETTING AROUND

a. How often do you go outside? _____

If you don't go out at all, explain why not.

b. When going out, how do you travel? (Check all that apply.)

Walk Drive a car Ride in a car Ride a bicycle

Use public transportation Other (Explain) _____

c. When going out, can you go out alone? Yes No

If "NO," explain why you can't go out alone.

d. Do you drive? Yes No

If you don't drive, explain why not.

16. SHOPPING

a. If you do any shopping, do you shop: (Check all that apply.)

In stores By phone By mail By computer

b. Describe what you shop for.

c. How often do you shop and how long does it take?

17. MONEY

a. Are you able to:

Pay bills Yes No Handle a savings account Yes No

Count change Yes No Use a checkbook/money orders Yes No

Explain all "NO" answers.

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? Yes No

If "YES," explain how the ability to handle money has changed.

18. HOBBIES AND INTERESTS

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

b. How often and how well do you do these things?

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

19. SOCIAL ACTIVITIES

a. How do you spend time with others? (Check all that apply.)

In person On the phone Email Texting Mail
 Video Chat (for example Skype or Facetime) Other (Explain) _____

b. Describe the kinds of things you do with others.

How often do you do these things?

c. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.)

Do you need to be reminded to go places? Yes No

How often do you go and how much do you take part?

Do you need someone to accompany you? Yes No

If "YES", explain.

d. Do you have any problems getting along with family, friends, neighbors, or others? Yes No

If "YES," explain.

e. Describe any changes in social activities since the illnesses, injuries, or conditions began.

SECTION D - INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

- | | | | |
|------------------------------------|-----------------------------------|-------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Walking | <input type="checkbox"/> Stair Climbing | <input type="checkbox"/> Understanding |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Seeing | <input type="checkbox"/> Following Instructions |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Memory | <input type="checkbox"/> Using Hands |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Talking | <input type="checkbox"/> Completing Tasks | <input type="checkbox"/> Getting Along With Others |
| <input type="checkbox"/> Reaching | <input type="checkbox"/> Hearing | <input type="checkbox"/> Concentration | |

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

b. Are you: Right Handed? Left Handed?

c. How far can you walk before needing to stop and rest? _____
 If you have to rest, how long before you can resume walking?

d. For how long can you pay attention? _____

e. Do you finish what you start? (For example, a conversation, chores, reading, watching a movie.) Yes No

f. How well do you follow written instructions? (For example, a recipe.)

g. How well do you follow spoken instructions?

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.)

i. Have you ever been fired or laid off from a job because of problems getting along with other people? Yes No

If "YES," please explain.

If "YES," please give name of employer. _____

j. How well do you handle stress?

k. How well do you handle changes in routine?

l. Have you noticed any unusual behavior or fears?

Yes

No

If "YES," please explain.

21. Do you use any of the following? *(Check all that apply.)*

Crutches

Cane

Hearing Aid

Walker

Brace/Splint

Glasses/Contact Lenses

Wheelchair

Artificial Limb

Artificial Voice Box

Other (Explain)

Which of these were prescribed by a doctor?

When was it prescribed?

When do you need to use these aids?
