

FUNCTION REPORT - ADULT

	For SSA Use Only Do not write in this box Related SSN _____ Number Holder _____
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SECTION A - GENERAL INFORMATION

1. NAME OF PERSON APPLYING FOR OR RECEIVING DISABILITY BENEFITS <i>(First, Middle Initial, Last)</i>	2. SOCIAL SECURITY NUMBER
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3. YOUR DAYTIME TELEPHONE NUMBER *(If there is no telephone number where you can be reached, please tell us the name and daytime number of a person with whom we can leave a message for you.)*

() _____ Your Number Message Number None
Area Code Phone Number

4. LIST any symptoms related to your illnesses, injuries, or conditions.

5.a. Do you live in a: (Check where you live **NOW**)

1. House? 2. Apartment? 3. Boarding House? 4. Nursing Home?
 5. Shelter? 6. Group Home? 7. Other?

If you checked "Other," please **DESCRIBE** where you live.

b. Do you live *(Check your **CURRENT** living arrangement)*

1. Alone? 2. With Family? 3. With Friends?
 4. Other?

If you checked "Other," please **DESCRIBE** your living arrangement.

SECTION B - INFORMATION ABOUT YOUR ABILITIES (continued)

c. For each of the activities below, please check the box that best describes what you can do.

Number of hours I can walk before having to rest. 0 1 2 3 4 5 6 7 8

Number of hours I can stand before having to rest. 0 1 2 3 4 5 6 7 8

Number of hours I can sit before having to change position. 0 1 2 3 4 5 6 7 8

How often I can bend Frequently Occasionally Never

Amount of pounds I can lift frequently 10 20 30 40 50

Amount of pounds I can lift occasionally 10 20 30 40 50

How often I can reach my arms out and up Frequently Occasionally Never

d. Do you **USE** any of the following? (Check all that apply.)

- | | | |
|---|---|--|
| 1. Crutches <input type="checkbox"/> | 2. Cane <input type="checkbox"/> | 3. Hearing Aid <input type="checkbox"/> |
| 4. Walker <input type="checkbox"/> | 5. Brace/Splint <input type="checkbox"/> | 6. Glasses/Contact Lenses <input type="checkbox"/> |
| 7. Wheelchair <input type="checkbox"/> | 8. Artificial Arm or Leg <input type="checkbox"/> | 9. Artificial Voice Box <input type="checkbox"/> |
| 10. Other Assistive Device <input type="checkbox"/> | | |

e. If you do not use any type of assistive device, go to g.

If you use an assistive device, **LIST** each type of assistive device you use, **DESCRIBE** when you use it, and **TELL** if it does or does not help you in your daily activities.

f. If the assistive device(s) was prescribed, **TELL** who prescribed it and the **DATE** it was prescribed.

SECTION B - INFORMATION ABOUT YOUR ABILITIES (continued)

g. Have your illnesses, injuries, or conditions affected your ability to:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Pay attention? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Understand? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Finish something you start? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Read a newspaper, magazine, or book? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Watch a movie? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Follow written instructions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Follow spoken instructions? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Handle changes in your routine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Handle stress? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

h. If you checked "**Yes**" for any activity in **g.**, please **LIST** the activity and **EXPLAIN WHAT** has changed because of your illnesses, injuries, or conditions.

7. MEDICATION, TREATMENT, OR OTHER METHOD

a. Do you take any prescription or non-prescription medications for your illnesses, injuries, conditions, or symptoms? Yes No
(Go to **b.**)

If "YES," please answer **1.**, **2.**, and **3.**

1. Do you take the medications in the dosages and at the frequency instructed? Yes No
If "No," please **EXPLAIN** why not and at **WHAT** dosage and frequency you take the medication.

2. Do you need help or reminders taking medicine? Yes No
(Go to **3.**)

What help or reminders do you need? Please **DESCRIBE.**

3. Has the medication affected your ability to do things (for example, after taking your medication you can bend more easily; the medication makes you sleepy?) Yes No
(Go to **b.**)

Please **EXPLAIN** the effect the medication you take for your illnesses, injuries, or conditions has on your ability to do things

SECTION B - INFORMATION ABOUT YOUR ABILITIES (continued)

b. Is there any treatment, other than medication, (for example, acupuncture or physical therapy) or other method (for example, lying flat on your back or changing position) that you use now or that you have used in the past for your illnesses, or conditions or symptoms? Yes No
(Go to **Section C.**)

If "Yes," please answer **1.**, **2.**, **3.**, and **4.**

1. For each treatment or other method you use or have used, **LIST** the **TYPE** and the **DATE** you started the treatment or other method and the **DATE** treatment ended. If you are still taking the treatment or using the other method, show "ongoing."

2. Was the treatment or other method recommended by a doctor or other health care professional who treated or examined you? Yes No
(Go to **3.**)

Please **LIST** the treatment or other method, the **NAME** of the doctor or other health care professional who recommended it, and **HOW OFTEN** you take the treatment or use the other method.

3. Do you need help or reminders to follow your treatments or other methods? Yes No
(Go to **4.**)

What kind of help or reminders do you need? Please **DESCRIBE.**

4. Have the treatments or other methods you use or have used affected your ability to do things (for example, changing positions relieves pain in your back; the treatments leave you tired)?
 Yes No
(Go to **Section C.**)

Please **EXPLAIN** the effect the treatments or other methods you use for illnesses, injuries, or conditions have on your ability to do things. Please be **SPECIFIC.**

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES

8. PERSONAL CARE

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

- | | | | | | |
|---------------------|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Dress? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 5. Shave? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Shower or bathe? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 6. Feed yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Care for hair? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 7. Use a toilet? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Care for teeth? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 8. Do some other personal care activity? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

b. For each item that you checked "Yes," **LIST** the number of the item and **DESCRIBE** how your illnesses, injuries, or conditions affect that activity (for example, it takes more time to dress, you have a simpler hair style, you changed to an electric razor).

c. Do you need help or reminders to care for your personal needs? Yes No
(Go to 9.)

What kind of help or reminders do you need?

9. Do your illnesses, injuries, or conditions affect your sleep? Yes No
(Go to 10.)

Please **EXPLAIN**.

10. Do you take care of:

a. Another person (for example, your spouse, child, grandchild, parent, or friend)?

- Yes No Never Did This

b. A pet or other animal? Yes No Never Did This

If you answered "No" or "Never Did This," to **a.** and **b.**, go to question **11.**

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES (continued)

If you answered "Yes" to **a. or b.:**

1. Who or what do you take care of?

2. What do you do for them?

3. Does someone help you take care of the other person, pet or other animal? Yes No
Please answer **a. and b.** (Go to 11.)

a. Who helps you?

b. How do they help you?

11. Has there been any change in what you can do because of your illnesses, injuries, or conditions?

Yes No
(Go to 12.)

Please **EXPLAIN.**

12. GETTING AROUND

a. Do you go outside your home alone? Yes No
(Go to b.)

Please **EXPLAIN** why you do not go out alone.

b. When you go outside your home, do you: (Check **ALL** that apply)

- | | | |
|---|------------------------------|-----------------------------|
| 1. Walk? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Drive yourself? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Go as a passenger in a car, truck, or other private vehicle? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Use public transportation? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Ride a bicycle? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Other? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If you checked "Yes" for "Other," please **DESCRIBE.**

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES (continued)

c. If you checked **b.2** (Drive yourself?), please **TELL** how **OFTEN** you drive and how **FAR** you can drive comfortably.

d. Even if you do not drive yourself when you go outside your home, can you drive? Yes No

1. If "Yes," please **EXPLAIN** why you do not drive yourself when you go outside your home (for example, you do not have a current driver's license).

2. If "No," please **EXPLAIN** why you cannot drive (for example, you never learned how to drive).

e. Has there been any change in how you travel to places outside your home (for example, to a doctor, shopping, visiting) because of your illnesses, injuries, or conditions? Yes No

(Go to **13.**)

Please **DESCRIBE** the change.

13. MONEY

a. Are you able to:

- 1. Use your money by yourself? Yes No
- 2. Count change? Yes No
- 3. Handle a savings account? Yes No
- 4. Use checks or money orders? Yes No

If you were able to do all of the listed activities, go to **b.**

For any item that you checked "No," please **EXPLAIN** why you are not able to do the activity.

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES (continued)

- b. Has there been any change in your ability to manage your money or pay your bills because of your illnesses, injuries, or conditions? Yes No
(Go to 14.)

Please **DESCRIBE** the change.

14. MEALS

- a. Do you prepare your own meals? Yes No
(Go to b.)

Please **EXPLAIN** why you do not prepare your own meals.

- b. What meals do you usually prepare? (Check **ALL** that apply)

Breakfast Lunch Dinner

- c. Normally do you (Check the answer that is **MOST OFTEN** true)

1. Order take-out food?
2. Make simple meals, needing little preparation (dry cereal and mix, sandwiches, canned soup)?
3. Use ingredients requiring peeling or slicing vegetables, frying, baking or roasting meat, or following a recipe?

- d. Has there been any change in the way you prepare meals (for example, the type of meals you prepare, the time you spend preparing meals, how often you prepare meals) because of your illnesses, injuries, or conditions? Yes No
(Go to 15.)

Please **DESCRIBE** the changes.

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES (continued)

15. HOUSE AND YARD WORK

a. Do you do any house or yard work (for example, wash dishes, laundry, ironing, dusting, vacuuming, household repairs, home improvement projects, mow a lawn, gardening)?

Yes No

If "No," please **EXPLAIN** why not.

If "Yes," **LIST** the household or yard work that you do.

b. Has there been a change in the **way** you do the house or yard work listed in **15.a.** or in the **time** it takes you to do the work because of your illnesses, injuries, or conditions?

Yes No
(Go to **c.**)

Please **LIST** any house or yard work you do in which there has been a change and **DESCRIBE** the change. Please be **SPECIFIC**.

c. Do you need help, reminders, or encouragement to do any of the house or yard work you do?

Yes No
(Go to **16.**)

LIST each activity for which you need help, reminders, or encouragement, and **DESCRIBE** why you need the help, reminders, or encouragement, and **LIST** who provides the help, reminders, or encouragement.

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES (continued)

16. SHOPPING

a. Do you do any shopping for yourself or others? Yes No
(Go to d.)

Do you shop: (Check 'YES' for **ALL** that apply)

1. In the stores? Yes No 3. By mail (catalogue)? Yes No
2. By phone? Yes No 4. By computer? Yes No

b. Do you shop for?

1. Groceries Yes No
(Go go 2.)

HOW OFTEN do you shop for groceries?

2. Clothing (for yourself or others)? Yes No
(Go go 3.)

HOW OFTEN do you shop for clothing?

3. Other shopping? Yes No
(Go go d.)

DESCRIBE what you shop for and **HOW OFTEN** you do this type of shopping.

c. Has there been any change in the way you shop (for example, you now shop more by phone), or in your shopping habits (for example, you shop less often) because of your illnesses, injuries, or conditions? Yes No
(Go go 17.)

Please **DESCRIBE** the change. Please be **SPECIFIC**.

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES (continued)

d. If you **do not** shop for yourself or others, is this a change? Yes No

Please **DESCRIBE** the change. Please be **SPECIFIC**.

17. SOCIAL ACTIVITIES

a. Do you do things with other people (in person, on the phone, on the computer, etc.)?

Yes No
(Go to c.)

Please **DESCRIBE** the kinds of things you do with other people.

b. How often do you do each of the things you described in a.?

c. Are there things you do outside your home or places you go on a regular basis (religious services, community center, sports events, social groups, visit with family or friends, etc.)?

Yes No
(Go to e.)

For each thing you do or place you go, **TELL** how often you do the activity or go to the place and what you do there (for example, weekly Sunday morning church service, monthly community meeting-treasurer, watch weekly little league games during season).

d. Has there been any change in your social activities because of your illnesses, injuries, or conditions? Yes No

If "Yes," **DESCRIBE** the change. Please be **SPECIFIC**.

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES (continued)

e. Do you get along with others (family, friends, neighbors, etc.)? Yes No
(Go to f.)

Please **EXPLAIN** why not. Please be **SPECIFIC**.

f. Do you get along with authority figures (for example, police, a boss, landlord, or teacher)?
 Yes No
(Go to g.)

Please **EXPLAIN** in what way you do not get along with authority figures.

g. Have you ever quit, been fired, or been laid off from a job because of your injuries, illnesses, or conditions?
 Yes No
(Go to 18.)

Please **EXPLAIN** what happened.

18. HOBBIES AND INTERESTS

a. Do you have any hobbies or interests (for example, reading, watching TV, sewing, playing, or watching sports, bingo, playing cards, fishing, hunting, camping, gardening, or computer)?

Yes No Never Had Any Hobbies or Interests

If you checked "No" or "Never Had Any Hobbies or Interests" go to **Section D**.

If **"Yes,"** please **LIST** each hobby or interest and **HOW OFTEN** you do it.

SECTION C - INFORMATION ABOUT YOUR DAILY ACTIVITIES (continued)

b. Has there been any change in your ability to do any of the hobbies or interests you listed or the time you spend on them because of your illnesses, injuries, or conditions?

Yes No
(Go to **Section D.**)

Please **DESCRIBE** the change. Please be **SPECIFIC**.

SECTION D - OTHER INFORMATION

19. Answering this question is optional. Is there anyone you haven't already told us about (relative, friend, neighbor, former coworker, or boss) that we may contact (other than your doctors or the person you named on your disability report) who knows about your illnesses, injuries, or conditions?

Name _____ Relationship _____

Address _____
(Number, Street, Apartment Number (if any), P.O. Box or Rural Route)

_____ City State ZIP Code Daytime Phone Number

If you completed this form for yourself, go to Section E.

If you completed this form for the person applying for or receiving disability benefits, please complete the information in question 20. When you are done with questions **20.a.** and **20.b.**, go to **Section E.**

20. a. What is your relationship to the disabled person (for example, spouse, neighbor, friend)?

b. Please **EXPLAIN** why you are completing this form for the person applying for or receiving disability benefits.
