Assessment of Functional Status

Patient Name: ______________________________ Date: __________________

Your Name: ______________________________

Relationship to Patient: ______________________________

Instructions

- For each item below, please mark whether there has been a change since before the current problems began. What is a problem now that was not a problem at the patient's normal baseline?
- Please use the comments section to describe the concerns that led to this evaluation.
- Please be open and frank.

Learning and Memory	Is there a change?	
Often repeats self	yes	no
Forgets conversations	yes	no
Forgets events	yes	no
Loses track of appointments	yes	no
Misplaces objects	yes	no

Language	Is there a change?	
Word-finding	yes	no
Pronunciation	yes	no
Understanding	yes	no
Writing and spelling	yes	no
Arithmetic	yes	no

Complex Tasks	Is there a change?	
Balances a checkbook	yes	no
Pays bills on time	yes	no
Manages medications correctly	yes	no
Cooks a meal	yes	no
Follows a recipe	yes	no
Does household chores/repairs	yes	no
Uses the telephone	yes	no
Drives a car safely	yes	no
Shops alone	yes	no

Reasoning	Is there a change?	
Manages problems at home	yes	no
Makes travel arrangements	yes	no
Decides on car maintenance	yes	no
Arranges household repairs	yes	no
Organizes a shopping list	yes	no

Spatial Ability	Is there a change?	
Finds the way to a familiar place	yes	no
Follows a map or GPS to a new place	yes	no
Recognizes familiar places & people	yes	no

Personality and Behavior	Is there a change?	
More passive	yes	no
Less responsive in conversation	yes	no
More irritable and/or angry	yes	no
More suspicious	yes	no
Socially inappropriate	yes	no
Hallucinations	yes	no

Personal Care	Is there a change?	
Dressing	yes	no
Bathing	yes	no
Grooming	yes	no
Toileting	yes	no
Eating	yes	no
Walking	yes	no

Comments: (please continue on the back of the page if necessary)