FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only
Do not write in this box.

Related SSN – –

Number Holder

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.)*

( ) –
Area Code *Phone Number*

☐ Your Number ☐ Message Number ☐ None

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. Do you spend time with others? *(In person, on the phone, on the computer, etc.)* ☐ Yes ☐ No

If "YES," describe the kinds of things you do with others. ______________________________

____

How often do you do these things? ______________________________

b. 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

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

If "YES," explain. ______________________________

____

d. 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:

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along With Others
☐ Reaching	☐ Hearing	☐ 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? ____________________

____

22. Do you currently take any medicines for your illnesses, injuries, or conditions? ☐ Yes ☐ No

If "YES," do any of your medicines cause side effects? ☐ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

CLAIMANT SIGNATURE:

Name of person completing this form (Please print)		Date *(month, day, year)*
Address (Number and Street)	Email address (optional)	
City	State	Zip Code