Daily Activities Worksheet

This Daily Activities Worksheet asks for information about your impairment that your doctor needs for an accurate report, and Social Security needs for understanding the impact of your illness/injury.

Name of Applicant: _____

Social Security #: _____ Date: _____

Name of Person Helping to Compete This Form:

_____

A. ARE YOU WORKING?

1. Are you working?

2. If not, can you work all day, five days a week, year round?

3. Did your health stop you from working?

4. If so, when did you stop being able to work (month, day, year)?

B. ACTIVITIES OF DAILY LIVING

1. TYPICAL MONTH. Please state how many good, fair, and bad days you have each month. (Consider a month to be 30 continuous days.)

a. GOOD DAYS -- days when you do well and complete all living and home care activities.
Total good days a month: _____

b. FAIR DAYS -- days when you function with serious difficulty and fail to complete some living and home care activities.
Total fair days a month: _____

c. BAD DAYS -- days when you function very poorly and fail to complete most living and home care activities.
Total bad days a month: _____

d. Please describe your TYPICAL MONTH in terms of GOOD, FAIR, and BAD days, and give exmaples of how bad days or fair days are worse.

2. Are there days when you don't go out because of your health? If yes, how many days a month does your health keep you in? _____

Please explain:

3. Compared with a year ago, are you functioning: Better? Worse? About the same? Please explain.

4. Caring For Yourself

a. PERSONAL NEEDS. Do you have serious difficulty taking care of any personal needs, including the following, due to your medical condition? (Check and describe any that apply, and give additional examples if these don't cover your situation.)

___Bathing
___Shaving
___Hair care
___Dressing
___Eating
___Sleeping
___Using the toilet
___Getting to the toilet
___Using stairs
___Holding onto objects
___Doing things on time
___Finishing things
___Making decisions
___Taking medicines on time/in right dose
___Understanding/following instructions
___Keeping well-informed
___Using the telephone
___Personal business/finance
___Caring for others
___Visiting people
___Shopping
___Getting places
___Recreation
___Hobbies
___Group activities, like church or clubs

Other Activities? Describe:

b. MEALS. Do you prepare or serve meals? If so, what meals do you do?

(I) BREAKFAST. Describe what you do. How many days a month? ____

(ii) LUNCH. Describe what you do. How many days a month? ____

(iii) DINNER. Describe what you do. How many days a month? ____

(iv) Does anyone help with meals? If yes, please explain what you do and what they do.

5. Caring For The Place You Live.

a. THINGS YOU DO. Describe the home care activities you do regularly.

b. THINGS OTHER PEOPLE DO. Describe the home care activities which other people do around the place you live.

c. THINGS THAT DON'T GET DONE. Describe any home care activities which need to be done, but do not get done because of your health.

d. THINGS YOU DID BEFORE THAT YOU DON'T DO ANYMORE. In the past, did you do things you don't do now due to your health? If so, describe them and why you don't do them now.

C. WORK RELATED ACTIVITIES. Do you have serious difficulty doing any of the following on a sustained basis? (Describe any that apply.)

___Sitting
___Standing
___Walking
___Crawling
___Crouching/squatting
___Speaking
___Hearing
___Seeing
___Remembering
___Understanding
___Carrying out instructions
___Concentrating
___Lifting
___Carrying
___Pushing/pulling with hands
___Pushing/pulling with legs
___Reaching up, out, down
___Finishing what you start
___Grasping, handling, fingering
___Bending over
___Keeping your balance
___Getting along with people who supervise you
___Getting along with people who annoy you
___Adjusting to changes
___Working productively all day, every day, year round
___Traveling (driving or using public transportation)
___Functioning in bad environments, like those involving risks, heat or cold or humidity, pollutants, fumes, drafts, irritants like noise or vibration

OTHER ACTIVITIES. Describe:

D. DO YOU REMEMBER ANYTHING ELSE THAT MIGHT HELP YOUR DOCTOR OR SOCIAL SECURITY UNDERSTAND YOUR IMPAIRMENTS? If yes, please explain.

APPLICANT STATEMENT

The information listed above is complete and correct to the best of my knowledge.

Signature of Applicant _____

Date_____