Activities of Daily Living (ADL)

Instructions: Please mark an "**X**" in the check box that best corresponds to your answer for each question.

For columns B and/or C, if your answer is 'No', go to the next question.

	A Do you have **any difficulty** with the activity below?			**B** Are you **unable** to do this activity **on your own**?			**C** Are you **unable** to do this activity **on your own because** of a **health** or **physical problem**?	
Activity	**No**	**Yes**		**No**	**Yes**		**No**	**Yes**
1. Bathing or showering?	☐	☐	If Yes →	☐	☐	If Yes →	☐	☐
	*If **No** go to Ques. 2*							
2. Dressing?	☐	☐	If Yes →	☐	☐	If Yes →	☐	☐
	*If **No** go to Ques. 3*							
3. Eating?	☐	☐	If Yes →	☐	☐	If Yes →	☐	☐
	*If **No** go to Ques. 4*							
4. Getting in or out of bed or chairs?	☐	☐	If Yes →	☐	☐	If Yes →	☐	☐
	*If **No** go to Ques. 5*							
5. Walking?	☐	☐	If Yes →	☐	☐	If Yes →	☐	☐
	*If **No** go to Ques. 6*							
6. Using the toilet?	☐	☐	If Yes →	☐	☐	If Yes →	☐	☐