

Shared Care Free Clinic

(Jackson County Free Clinic, Inc)

17611 E US 24 Highway, Suite 103

Independence MO 64056

Message line: 816-404-6455 Fax: 816-478-3713

Functional Evaluation

Date: _____

Patient Name: _____ **DOB:** _____

Please answer the following questions. Please use the back of the form if you need more room.

When was the last time you felt well? _____

What is the most frustrating part of your current condition? _____

When was your last job? _____

What do you do in this job or in your most recent job? _____

What things are/were hard to do in that position? _____

How did your medical conditions affect your ability to do the work? _____

Do you have any difficulty driving? Y N

Do you have difficulty with remembering things? Y N

Do you have difficulty with learning new information or activities? Y N

Do you have difficulty sleeping? Y N

If yes, how many hours do you sleep at a time? _____

What wakes you from sleep? _____

How many hours total do you get to sleep at night? _____

Do you have pain? Y N

Where _____

When did each pain start? _____

How do you treat your pain? _____

What did not work for your pain? _____

What does your pain keep you from doing _____

On a bad day, how much pain do you have? Rate 1 (little) through 10 (severe) _____

On a good day, how much pain do you have? Rate 1 through 10 _____

When you treat your pain, how much pain do you have? Rate 1 through 10 _____

How long do you get relief of pain? _____

Do you have difficulty with your balance? Y N _____

Do you have difficulty writing or gripping small objects? Y N _____

How long can you stand without sitting to rest? _____

How long can you sit without having to stand? _____

How far can you walk without getting out of breath? _____

Do you have difficulty with stairs? Y N _____

Do you have difficulty grocery shopping? Y N _____

Do you have difficulty lifting? Y N _____

Do you have difficulty with your housework? Y N _____

Do you have difficulty showering or bathing? Y N _____

Do you have difficulty getting on or off the toilet? Y N _____

Do you have difficulty with getting dressed? Y N _____

Do you have difficulty wearing or getting on your shoes? Y N _____

Do you use anything to help you walk? Walker? Cane? Touching the walls or furniture? _____

What else is important for the doctor to know about you? _____
