

# SELF ASSESSMENT FORM

<b>PART ONE: GROOMING</b>		
I am able to	bend over to utilize a sink	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	see clearly without glasses or contacts to groom myself	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	see clearly with glasses or contacts to groom myself	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	brush my teeth	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	brush/style my hair	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	use a hand-held razor to shave	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	use an electric razor to shave	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	insert and remove electrical plugs	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	bend over to use the sink.	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into a bathtub without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get out of a bathtub without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into and out of a shower without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach under the sink to retrieve items	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	lift items down from a shelf	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get onto a toilet seat without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get up from a toilet seat without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	am able to utilize a pan if I vomit	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach a sink or toilet to vomit	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach a toilet when needed acutely	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access/utilize a bedside bed pan	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access/utilize a bedside toilet chair	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	clean up accidents or spills without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	clean up accidents or spills with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

<b>PART TWO: DRESSING</b>		
I am able to	pull clothes over my head	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	step into and lift pants and underwear	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	fasten buttons	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	fasten snaps	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	pull zippers	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	slip my arms into sleeves	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	tie shoe laces	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	put on shoes	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	pull on socks	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	gather laundry	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	lift a laundry basket	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	carry gathered laundry or basket	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	load and operate a washer/dryer	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	clear the lint screen	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	turn off the water supply to the washer	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	insert and remove electrical plugs	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate a clothes iron and ironing board	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

<b>PART THREE: KITCHEN, COOKING, GROCERIES</b>		
I am able to	reach into lower cabinets to retrieve items.	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach overhead to retrieve items and lower them to counter height	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate the oven, stove, microwave, and/or dishwasher.	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	lift arm to pour items	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	wash and dry dishes by hand	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	lift a tea or coffee pot or cup	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	utilize a knife to cut food	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	utilize a fork	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	utilize a spoon	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	insert and remove electrical plugs	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get to a grocery store	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate a store on foot unassisted	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate a cart through the store	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	use a scooter to navigate the grocery store	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	lift items down from a shelf	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	kneel to retrieve items from a low shelf	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	place the groceries into a car or car trunk	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	carry groceries into the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	put groceries away once in the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	chew solid foods	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	swallow solid foods	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	chew semi-solid foods	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	swallow semi-solid foods	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	swallow liquids	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

<b>PART FOUR: HOME CARE</b>		
I am able to	replace light bulbs in fixtures when they burn out	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get onto the floor without holding onto something	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get onto the floor while holding onto something	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get onto the floor at any time	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	carry items from surface to surface without spilling or dropping them.	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	sweep or operate a vacuum cleaner	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	mop a floor	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the electrical breaker box	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the water shut off valve in an emergency	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the gas shut off valve in an emergency	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach a security control panel	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate a security control panel	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the thermostat and air condition controls	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate the thermostat and air condition controls	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the smoke and/or carbon monoxide alarms	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate the smoke and/or carbon monoxide alarms	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	hear an alarm when it sounds	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	react to the alarm in a timely manner	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access telephone services	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access the telephone itself	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

PART FOUR: HOME CARE - CONTINUED		
I am able to	hear the phone when it rings	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	answer the phone in a timely manner	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach down to clean spills	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	dust or wipe surfaces you can reach from a standing position	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	dust or wipe surfaces you cannot reach from a standing position	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	clean a toilet	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	lift the lid to the toilet and stop it from overflowing	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	plunge a toilet	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	clean up after an overflow of the toilet	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the water turn off valves to the toilet	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	clean the appliances	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	wipe off counters and tables	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reposition furniture when needed	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate my home without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate my home with mobility aids	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	maintain my home without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	maintain my home with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	remain in my current home because of my limitations	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the locks on the doors	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate the locks on the doors	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the locks on the windows	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate the locks on the windows	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	open the window	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	close the window	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	have a pet in the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	care for a pet in my home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

PART FIVE: MOBILITY		
I am able to	sit in an upright chair	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	sit in a chair without holding onto something	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	sit in a chair by holding onto something	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	sit in a reclining chair	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	activate the footrest on a reclining chair	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into bed without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get out of bed without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	roll over in bed without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	roll over in bed with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get out of a bed quickly in case of an emergency	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	have access to a telephone when in bed	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	have access to an emergency call button when in bed	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	walk unaided in the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	walk while holding onto things in the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	walk unaided outside the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate uneven surfaces without aid	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate uneven surfaces with aid	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	go up stairs without holding onto the railing	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	go up stairs while holding onto the railing	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

# SELF ASSESSMENT FORM

PART FIVE – MOBILITY - CONTINUED		
I am able to	go down stairs without holding onto the railing	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	go down stairs while holding onto the railing	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	walk with a cane	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	walk with a rolling device	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into a wheelchair without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get out of a wheelchair without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate the wheelchair inside the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate the wheelchair outside of the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	transfer to a motorized scooter	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate a motorized scooter	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate my home with a rolling device	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate my home with a wheel chair	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate my home with an electrical scooter	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into and out of the home with a rolling device	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into and out of the home with a wheel chair	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into and out of the home with an electrical scooter	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get a rolling device into and out of a motor vehicle alone	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get a rolling device into and out of a motor vehicle with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get a wheel chair into and out of a motor vehicle alone	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get a wheel chair into and out of a motor vehicle with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get an electric scooter into and out of a motor vehicle alone	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get an electric scooter into and out of a motor vehicle with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	have access to a handicap-friendly motor vehicle	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into a vehicle without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get into a vehicle with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get out of a vehicle without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get out of a vehicle with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate the steering wheel of a vehicle with both hands	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	operate the steering wheel of a vehicle with one hand	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	push the gas, break, and/or clutch pedal with my right foot	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	push the gas, break, and/or clutch pedal with my left foot	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	rotate my neck to look to the right	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	rotate to my neck to look to the left	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	rotate my neck and shoulders to look behind	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	tilt my head forward to look down	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	tilt my head backward to look up	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	drive a car while in reverse	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access emergency car services such as AAA, road side service	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	see well at night	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	see well in inclement weather	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	remain awake and alert at all times when behind the wheel	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	control the spasms well enough to maintain control of a vehicle	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access public transportation (such as subways, buses, trains, taxis)	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

# SELF ASSESSMENT FORM

PART FIVE – MOBILITY - CONTINUED		
I am able to	follow the directions required for using public transportation stations	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate airports without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate airports with assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	navigate local transportation stations	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access specialized transportation services	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access emergency alert devices or services in my area	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

PART SIX: MANAGING FINANCES		
I am able to	use the telephone without assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	use a computer, tablet, or other handheld electronic device	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	hold a book or tablet of paper	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	utilize a remote control	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	insert and remove electrical plugs for chargers	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach electrical outlets	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the electrical breaker box	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access cable or internet services in my area for the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access cable or internet services in my area outside the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	connect devices to other devices	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	reach the internet or telephone outlets	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	send and collect the mail	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	write by hand using a pen or pencil	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	keyboard/type	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	write checks and keep a register	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	seal envelopes	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get to a branch of my bank	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	do my banking in person	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	do my bill paying in person	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	do my banking online	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	do my bill paying online	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	meet my monthly financial obligations	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access health insurance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access public health assistance programs	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	qualify for social security disability	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	qualify for social security retirement health care plans	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access short-term disability benefits	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access long-term disability benefits	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access a health savings account	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access an annuity plan through an insurance company	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	perform my regular duties at work	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	perform modified duties at work	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	change my current position for one that accommodates my limitations	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access national or local aid for people with disabilities	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access financial planning assistance	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access work placement services	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	perform some type of work inside the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	access educational opportunities for people with disabilities	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never

PART SEVEN: SOCIAL AND LEISURE ACTIVITIES		
I am able to	participate in my favorite hobbies at home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	participate in my favorite hobbies outside the home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	transport myself to leisure activities	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get transport to leisure activities by friends or family	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get transport to leisure activities by public transportation	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	participate in local support groups, spiritual counsel, or therapy	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	transport myself to local support groups, spiritual counsel, or therapy	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get transport to support groups, spiritual counsel, or therapy by friends or family	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get transport to support groups, spiritual counsel, or therapy by public transport	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	am able to transport myself to visit friends	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get transport to friends and family by friends/family	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	get transport to friends and family by public transportation.	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never
I am able to	have friends and family visit my home	<input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Never