Independent Living Therapy Screen

Resident name:_____ Date:_____

1. I am having difficulties with or have noticed changes in the last year with the following:

☐Dressing myself
- ☐Shirt
- ☐Pants
- ☐Bra
- ☐Socks
- ☐Shoes
- ☐Belt
- ☐Buttons/zippers

☐Bathing or showering

☐Shopping

☐Driving

☐Reaching high/low areas

☐Keeping up with my appointments

☐Word finding

☐Change in voice
- ☐Volume
- ☐Tone
- ☐Raspy/harshness

☐Walking
- ☐Fearful of falling
- ☐Unsteady
- ☐Painful
- ☐Weakness

☐Using my assistive device:
- ☐Power wheelchair
- ☐Manual wheelchair
- ☐Rolling walker
- ☐Rollator
- ☐Cane
- ☐Other:_____

☐Walking to the bathroom

☐Getting in/out of the shower

☐Getting in/out of the bed

☐Cooking my meals/preparing food

☐Doing my laundry

☐ Incontinence (controlling bowel or bladder)
- ☐Bladder
- ☐Bowel

☐Making my bed

☐Writing a check

☐Balancing my checkbook

☐Paying my bills on time

☐Managing my medications

☐Swallowing

☐Appetite changes
- ☐Losing weight
- ☐Getting lost in familiar places
- ☐Memory

2. I am experiencing:

☐Pain

☐Shoulder ☐Elbow ☐Wrist ☐Fingers

☐Back ☐Hip ☐Knee ☐Feet

☐Other:_____

☐Swelling

☐Hands ☐Feet ☐Ankles ☐Other:_____

☐Weakness ☐Difficulties sleeping ☐Vision changes

☐Loss of balance ☐Sleeping more than usual ☐Tiredness

3. In the past year, I have started new medication(s): ☐YES ☐NO

   If you checked YES, list the new medications: _____

   _____

4. In the past year, I have fallen: ☐YES ☐NO

   Injuries? ☐YES ☐NO

5. In the past year, I have missed appointment(s): ☐YES ☐NO

6. In the past year, I have avoided social events, leisure activities, or hobbies I used to enjoy: ☐YES ☐NO

7. In the past year, I have had difficulty utilizing electronics

   ☐YES ☐NO

8. Additional information I would like to share:_____

   _____

   _____

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