Patient's Name __________________________________________

Date ______________________  Time ___________________________

Completed by (check one):

 Patient
 Family caregiver
 Health care professional caregiver
 Caregiver-assisted

Normal with no limitations

Not my normal self, but able to be up and about with fairly normal activities

Not feeling up to most things, but in bed or chair less than half the day

Able to do little activity and spend most of the day in bed or chair

Pretty much bedridden, rarely out of bed