Patient’s Name ____________________________________________________________

Date _________________________ Time ________________________________

Completed by (check one):

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

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