

Daily Living Assessment

Individual's Name: _____

| | Yes | No | Comments |
|--|-----|----|----------|
| Is able to feed self? | | | |
| Is able to prepare meals safely? | | | |
| Completes laundry tasks independently? | | | |
| Is able to dress without assistance? | | | |
| Can bathe/shower independently? | | | |
| Has the ability to use the toilet without assistance? | | | |
| Is able to get in and out of bed independently? | | | |
| Is able to maintain personal hygiene? | | | |
| Is able to perform housekeeping activities? | | | |
| Has the ability to manage time and follow a schedule? | | | |
| Is able to manage finances? | | | |
| Is able to sign name? | | | |
| Has the ability to clearly communicate needs? | | | |
| Has the ability to self-medicate? | | | |
| Is able to adapt to changes in environment? | | | |
| Is able to manage disability effectively? | | | |
| Has self-advocacy skills? | | | |
| Needs personal care attendant? | | | |
| Other: <input style="width: 250px; height: 20px;" type="text"/> <small>[Enter] for more</small> | | | |

Medical/disability restrictions that would affect this individual's daily living:

Daily Living Assessment

Potential Daily Living Adaptations/Recommendations

Evaluations:

Nutritional Health:

Other:

Training:

Safety Awareness/Evacuation Plan:

Use of Adaptive Equipment:

Money Management Training:

Self-Advocacy Training:

Independent Living Skills Training:

Other:

Daily Living Assessment

Equipment:

Dressing Aids or Adaptive Clothing:

Adaptive Utensils & Dishes:

Assistive Time Devices:

Adaptive Grooming Tools:

Emergency Response System:

Reachers/Low Tech Aids:

Environmental Controls:

Talking Watch/Clock:

Other:

EC Name: _____

Date: _____