HARRIS REGIONAL HOSPITAL SWAIN COMMUNITY HOSPITAL

Name: _____ Today's Date: _____

Occupational Therapy Questionnaire

Date of Injury: _____

Date of Surgery: _____

Do you **currently** need help or require assistance:

Dressing?	( ) Yes	( ) No	(•) N/A
Bathing?	( ) Yes	( ) No	(•) N/A
Eating?	( ) Yes	( ) No	(•) N/A
Preparing Meals?	( ) Yes	( ) No	(•) N/A
Grooming/ Hygiene?	( ) Yes	( ) No	(•) N/A
Toileting?	( ) Yes	( ) No	(•) N/A
Mobility?	( ) Yes	( ) No	(•) N/A
Housework?	( ) Yes	( ) No	(•) N/A
Yardwork?	( ) Yes	( ) No	(•) N/A
Transportation?	( ) Yes	( ) No	(•) N/A

What are your goals for therapy? _____

_____

Please return completed form to Occupational Therapy.