Occupational Therapy Self-Assessment Questionnaire

- Please provide the following information, or tick the correct answer. If any of the information on this form is incorrect, please amend before returning to us.

- Once completed, **please return to us within 2 weeks** and use the pre-paid envelope provided. When we have received the form, it will be reviewed and usually one or more of the following things will happen:

  - We may contact you for more information
  - We may offer you advice and information to help you
  - We may offer you equipment to help support you
  - We may need to meet you for a face to face assessment

- The more information you give us, the better we can assess your needs.

Title (Mr/Mrs/Miss/Ms)		**P No**	
Name			
Date of birth			
Full address and postcode			
Telephone number			
GP's name and address			

Please tell us about any health condition and how this affects you. Please include details of any hospital admissions in the last six months. Please tell us if you are being visited by any health professional eg District Nurse.

Approx height and weight if known:

Do you have difficulties with your sight, hearing or communication?

Yes ☐ No ☐

Additional comments (including telling us if you have a diagnosis)

Do you live alone?

Yes ☐ No ☐

If no, who lives with you?

Name:	Relationship:

What type of accommodation do you live in?
House ☐ Bungalow ☐ Flat ☐ (please state on what floor)
Other (please state) ☐

Who owns your home?
I am an owner occupier ☐ Private landlord ☐
Housing association (please state which association) ☐ Name:
Other (please state) ☐

1. Getting around indoors (including indoor steps and stairs)		
Are you able to get around indoors by yourself safely? (if yes, move onto Section 2)	Yes	No
If "No", please tell us about any support and/or equipment you currently use.		
What do you think may help *eg* stair rail or grab rails?		

2. Have you tripped, stumbled or fallen in the past six months?
Yes ☐ No ☐
If yes, please give us details below:

3. Getting in and out of my home		
Are you able to get in and out of your property safely? (if yes, move onto Section 4)	Yes	No
If "No", please tell us about any support and/or equipment you currently use.		
What do you think may help *eg* rails, the addition of a smaller step or a ramp?		

4. Getting in and out of bed		
Are you able to get in and out of your bed safely? (if yes, move onto Section 5)	Yes	No
If “No”, please tell us about any support and/or equipment you currently use.		
What do you think may help *eg* to make the bed higher or a bed rail? If you think it needs to be made higher, please give details of type of bed, number and type of legs on your current bed.		

5. Getting in and out of a chair		
Are you able to get in and out of your chair safely? (if yes, move onto Section 6)	Yes	No
If “No”, please tell us about any support and/or equipment you currently use.		
What do you think may help *eg* to make the chair higher? If you think it needs to be made higher, please give details of type of chair, type of legs/feet on your current chair:		

6. Using the toilet		
Are you able to use your toilet yourself safely? (if yes, move onto Section 7)	Yes	No
If “No”, please tell us about any support and/or equipment you currently use.		
Do you have problems getting to the toilet in time?		
Please tell us where your toilet is currently situated *eg* upstairs / downstairs or both.		
What do you think may help *eg* to make the toilet seat higher, a freestanding frame for support, rails, commode or urine bottle?		

7. Personal Care		
Are you able to wash independently? (if yes, move onto Section 8)	Yes	No
If "No", please tell us about any support and/or equipment you currently use.		
Are you able to strip wash? (if yes, move onto the next section)		
If "No", please tell us about any support and/or equipment you currently use.		
What do you think may help *eg* a perching stool?		
Do you use: Bath ☐ Separate Shower ☐ Overbath Shower ☐ Other ☐		
Are you able to use the bath/shower yourself safely? (if yes, move onto the next section)	Yes	No
If "No", please tell us about any support and/or equipment you currently use.		
What do you think may help *eg* bathboard, shower stool or rails?		

Preparing, cooking and eating meals

8. Preparing/eating my meals		
Are you able to prepare, cook and feed yourself independently? (if yes, move onto Section 9)	Yes	No
If "No", please tell us about any support and/or equipment you currently use.		
What do you think may help *eg* perching stool or lever taps?		

9. Do you currently receive any of the following?
Disability Living Allowance:
Care Component High ☐ Medium ☐ Low ☐
Mobility Component High ☐ Low ☐

Attendance Allowance: High ☐ Low ☐

Consent to Share Information:

Information recorded during this assessment may be shared with others involved in your care and/or treatment plan.

Do you consent to information recorded during this assessment being shared?	YES ☐ NO ☐
If "No", please specify what information you do not want to be shared and/or with whom	
Signed:……………………………………… ***Service User's representative/Service user (please circle)***	**Date: ………………..………………...**

About you

If you had help completing this form	
If you had help completing this form, can the person who has filled it in for you please sign and date below.	
Title (Mr/Mrs/Miss/Ms) (please circle)	**Name: ....** **Signature: ....**
Tel No	**Relationship to Service User:**

Thank you for completing this form.

Please return to us using the envelope provided.