MEASURES OF DAILY FUNCTION

Patient Name: ____________________ DOB: __________ Date:__________

Please circle the one best response for your current level of functioning for each activity described below:
Note: If there is an activity that you do not normally do even when well, please select the level you could perform at if you needed to do it.

Activities of Daily Living (bathing, dressing, feeding self, toilet) 1. Need some assistance 2. Slight difficulty 3. Minimal difficulty 4. No problem Laundry 1. Unable 2. Occasionally 3. Regularly in small steps or with help 4. Regularly without help Cooking 1. Unable 2. Take-out, breakfast, or simple lunch 3. Simple microwave or crockpot meal 4. Regular, freshly prepared meals Housekeeping 1. Unable 2. Light dusting, straighten up 3. Regular housekeeping only in small steps or with help 4. Regular housekeeping without help Grocery Shopping 1. Unable 2. Occasional (once or twice per month) 3. Frequent, but with assistance 4. No problem	Attending Social Activities 1. Unable 2. Infrequently 3. Occasionally (once or twice per month) 4. Frequently (weekly or more often) Driving 1. Unable 2. Very limited 3. Cautious, local trips 4. Distant trips or traffic Errands or Light Chores (e.g., post office, drop off of a child) 1. Unable 2. Zero to one per day 3. Two to three per day 4. No or few restrictions Walking (for daily living, not for exercise) 1. None, except from the bed to the bathroom 2. Limited to walking in the house 3. Able to walk where needed, but pace is much slower 4. Able to walk where needed at normal pace for most people Planning/Organizing/Making Decisions (Dinner Party, Vacation, Large Purchase) 1. Unable 2. Occasional (once per month) 3. Frequent, but not as much as desired 4. No problem
Do not write in this box: Sum of the above selections = __________ Functional Status Score (Max = 40)	
Over the past 7 days, how many days did you feel good? 0 1 2 3 4 5 6 7	How many days last week did you miss work, including housework or any other planned activity, because of your FM or CFS? 0 1 2 3 4 5 6 7