Functional Needs Information

Name: _____ **Date:** _____

Instructions: *Please answer the following questions to help us better understand your functional needs, the challenges that you face, and how these impact your day-to-day activities.*

What is your primary disability or function limitation? _____
_____

Describe other problems or difficulties: _____
_____
_____

Do you need assistance to get to and from places such as work, school or the grocery store?
❒ yes ❒ no ***Explain:***

Are you able to walk on your own without needing assistance?
❒ yes ❒ no ***Explain:***

Has learning new information ever been difficult for you?
❒ yes ❒ no ***Explain:***

Do you need assistance in writing?
❒ yes ❒ no ***Explain:***

Have you ever had difficulty hearing, speaking or seeing?
❒ yes ❒ no ***Explain:***

Have you ever needed help or accommodations to work or complete tasks?
❒ yes ❒ no ***Explain:***

Do you need help with your daily living skills such as bathing, dressing, or eating?
❒ yes ❒ no ***Explain:***