

Activities of Daily Living (ADL) Assessment Form

Please complete the following assessment by marking the level of independence for each activity.

Patient Information

Full Name:

Date of Birth:

Assessment Date:

ADL Assessment

Bathing:

☐ Independent ☐ Needs Assistance ☐ Dependent

Dressing:

☐ Independent ☐ Needs Assistance ☐ Dependent

Toileting:

☐ Independent ☐ Needs Assistance ☐ Dependent

Transferring:

☐ Independent ☐ Needs Assistance ☐ Dependent

Continence:

☐ Continent ☐ Incontinent ☐ Needs Assistance

Feeding:

☐ Independent ☐ Needs Assistance ☐ Dependent

Mobility:

☐ Independent ☐ Needs Assistance ☐ Dependent

Comments / Notes

Add any additional observations or notes...

Assessor Name:

Signature:

Date:

