FUNCTIONAL CAPACITY ASSESSMENT · ADULT INTAKE

PARTICIPANT (SELF) VERSION

Functional Capacity Assessment

Your story, in your words.

This form helps us understand how everyday life works for you before the assessment interview. Detailed examples can help us prepare a more accurate and useful report. Short answers, long answers and dot points are all welcome. You may complete the form over several sittings, and a support person may assist. You do not need to repeat information already provided. Please complete each applicable item in the standardised questionnaires, because every item contributes to the result.

Nisha Bal Principal Occupational Therapist

Registered Occupational Therapist · AHPRA OCC0001752238

Go at YOUR OWN PACE

Skip what DOESN'T APPLY

A support person CAN HELP YOU

PLEASE READ FIRST

How to fill in and *save this form*

This is a fillable PDF. You type your answers straight into the boxes on screen. Here is how to keep your answers safe.

SAVING YOUR ANSWERS

1	STEP 1 **Open it on a computer if you can**	Adobe Acrobat Reader is free and the most reliable. Some web browsers and phone apps do not save typed answers properly, so a computer is the safest choice.
2	STEP 2 **Type into the boxes**	Click a box and type. The small arrows mark boxes that scroll, so you can keep writing past the edge and nothing is lost. The larger boxes are an invitation to write more, and long answers are welcome.
3	STEP 3 **Save to your own computer as you go**	Use File then Save, or the save icon. You can stop and come back as many times as you like. Just save each time before you close it.
4	STEP 4 **Do not use Print to PDF**	That can flatten your answers into a picture and lose them. Always use Save.
5	STEP 5 **Upload when you are finished**	Save one last time, then upload the completed file through your intake link.

You can stop and save, and come back any time.

PLEASE READ FIRST

First, check that *saving works*

Please run this one quick test before you fill the whole form in, so you never lose your answers later.

Test that saving works

Type anything in the box below. Save the file to your own computer, then close it and open it again. If your text is still there, saving is working. If it has gone, open the form in Adobe Acrobat Reader on a computer and run the test once more.

TEST BOX

Type anything here, then save, close, and reopen to check it saved.

WHILE YOU FILL IT IN

Go at your own pace

Complete it across several sittings if you need to. Save as you go.

Skip what does not fit

Open questions may be skipped if they do not apply or you do not wish to answer them. If you choose to complete a standardised questionnaire, please answer every applicable item so that a complete result can be calculated.

PLEASE READ FIRST

A few things *to know*

These make the form easier, and help your report reflect your real life.

Plain words are best

Write the way you would say it. Detail about an ordinary day helps more than medical terms.

A support person can help

A partner, family member, carer, or support worker can read, explain, or type for you. The answers should still be the participant's own.

Some questions are sensitive

Questions about safety, mood, and past experiences are here so nothing important is missed. Share only what you are comfortable putting in writing.

Three parts

Part 1 is your daily life, Part 2 is your story, and Part 3 is Seeds profiles plus recognised questionnaires, with a short guide to which ones apply to you.

PLEASE READ FIRST

The more you tell us, *the better the report*

Your report is built from your words. Detailed real-life examples are evidence, and short answers and dot points are welcome too. Here is how to give this form what it needs, without repeating yourself.

GIVING US DEPTH

There is no limit	Every box scrolls, the small arrows show you where, and the file keeps every word you type. Long answers are not just accepted, they are read in full, and they carry weight in the report.
Draft anywhere, paste here	If a box feels small for what you have to say, write your answer in a notes app or a document first, take your time, then copy and paste it in. The box will take all of it.
Say it instead of typing it	Most phones and computers have free dictation built in. Tap the microphone on your keyboard and talk, and it types for you. Or talk while a support person types. Spoken answers are often the richest ones.
Repeat only where it counts	Part 3's recognised questionnaires must be asked in their exact words, so answer every applicable item there, even when it feels familiar. Each item forms part of its result. In the open questions, you never need to repeat yourself. Write 'see earlier answer' and add only what is new.

If you are not sure whether something is worth including, include it.

THE FORM BEGINS OVERLEAF

PART 1

PART 1 OF 3

About you and your daily life

I want to understand how your everyday life actually works, at home and out in the world. Answer what you can, and leave anything that does not fit.

WHAT'S IN THIS PART

Your home and living situation, your health and conditions, how a typical day goes, mobility and safety, everyday tasks at home, and how you work, study, and take part. Mostly short answers, with a couple of tick-box grids near the end.

A sentence or two is plenty. That everyday detail is what I use to picture how your day really goes.

You can stop and save at any time. Taking a break here and coming back later is a good idea.

PARTICIPANT

The person this assessment is for.

Participant's full name	
Preferred name and pronouns *For example: Emma (she/her), Sam (they/them).*	
Date of birth *DD / MM / YYYY*	
Address	
Best contact phone	
Best contact email	

SECTION 1.1

Who is completing this form

QUESTIONS | YOUR ANSWERS

Who is filling this in?

A support person can help you fill this in. The answers should still be the participant's own wherever possible.

- ○ The participant
- ○ A parent or family member
- ○ A support worker
- ○ Someone else

Name of the person completing this form

If you are the participant, you can write your own name or 'self'.

Relationship to the participant

For example: mother, partner, support worker. Leave blank if you are the participant.

Today's date

DD / MM / YYYY

SECTION 1.2

Living situation and home

QUESTIONS | YOUR ANSWERS

Living situation and anything you'd like us to understand

Who you live with, how long, anything important about family, culture, community, or routines at home.

Support network

People involved in your life: family, friends, neighbours, support workers, services.

NDIS status

- ◯ On NDIS
- ◯ Applying or planning to
- ◯ Not on NDIS
- ◯ Not sure

NDIS number (if any)

Plan management

If you are not yet on the NDIS, you can skip this.

- ◯ Self-managed
- ◯ Plan-managed
- ◯ NDIA-managed
- ◯ Not sure / NA

Plan dates (if active)

For example: 01/03/2025 to 28/02/2026.

Housing type

For example: unit, house, flat, supported accommodation.

Storeys

Single-storey, double-storey, etc.

Entry steps (number)

If you are not sure, you can estimate.

Handrails at entry

- ◯ Yes
- ◯ No
- ◯ Not sure

Bathroom type	◯ Walk-in shower ◯ Shower over bath ◯ Bath only ◯ Other / not sure
Grab rails in bathroom	◯ Yes ◯ No ◯ Not sure
Laundry access *For example: in home, shared, external, up or down stairs.*	
Smoke alarm working	◯ Yes ◯ No ◯ Not sure

SECTION 1.3

Health and conditions snapshot

QUESTIONS	YOUR ANSWERS
Main diagnoses or health conditions (in your own words) *For example: autism, ADHD, chronic pain, PTSD, anxiety, EDS.*	
Other diagnoses or health issues *Anything else that affects your day-to-day life.*	
When did things start becoming harder? *Approximate years, life events, or changes.*	

Any recent hospital stays or major changes in the last 12 months?

If yes, briefly describe what happened and when.

Assistive devices or equipment you currently use

For example: walking stick, walker, wheelchair, shower chair, braces, hearing aids, CPAP.

SECTION 1.4

Symptoms and how they affect you

QUESTIONS YOUR ANSWERS

Pain, average over the last 30 days

0 no pain, 10 worst pain you can imagine.

0 No pain 10 Worst possible

0 1 2 3 4 5 6 7 8 9 10

Pain, worst over the last 30 days

0 No pain 10 Worst possible

0 1 2 3 4 5 6 7 8 9 10

Pain, where is it, what triggers it, and what helps?

For example: back, knees, hands. Triggered by standing, walking, stairs, stress.

Fatigue pattern

Your usual energy through the day, e.g. mornings better, afternoons crash.

Recovery time after a shower (minutes)

Recovery time after grocery shopping (minutes)

If you do not do this, write not applicable.

Recovery time after vacuuming (minutes)

If someone else does this, write not applicable.

Days housebound in the last 30 days

Days you did not leave home at all.

Days mostly in bed or on the sofa (last 30 days)

An estimate is fine.

Sleep

Time you usually fall asleep, how often you wake, nightmares, pain or worry at night.

Bladder and bowel

Any urgency, accidents, pads, constipation, diarrhoea, or other concerns.

Skin and wounds

Any pressure areas, ulcers, infections, or wounds that need regular care?

Sensory sensitivities

Noise, light, touch, smell, crowds, textures. What is difficult, and what helps you cope?

SECTION 1.5

Thinking, memory, and organisation

QUESTIONS YOUR ANSWERS

Thinking and memory, what feels harder for you?

Remembering appointments, following instructions, decisions, planning steps in a task.

Any mix-ups with memory or organisation in the last 30 days?

Medication errors, nearly missing appointments, getting lost, money or bill errors.

SECTION 1.6

Mobility and safety

QUESTIONS YOUR ANSWERS

Max walking distance (metres)

How far you can usually walk on flat ground before you need to rest.

Max standing time (minutes)

Max sitting time (minutes)

Max lifting or carrying weight (kg)

For example: can lift 2 kg, can carry a light shopping bag.

Mobility aids and equipment

For example: cane, crutches, walker, wheelchair, rails, grab bars.

Falls in the last 3 months (number)

Falls in the last 12 months (number)

Falls, injuries and likely causes

What happened, where, and what you think caused them.

Physical near-misses or close calls (last 30 days)

Times you nearly fell, tripped, or had another accident but just avoided it.

Home and community safety concerns

Stove, shower transfers, steps, roads, crowds, getting lost, choking or swallowing concerns.

SECTION 1.7

Daily activities at home

QUESTIONS YOUR ANSWERS

Self-care and household tasks. Short answers or examples are helpful. Support levels for bathing, dressing and toileting are now in the Seeds ADL Support Profile in Part 3.

Shower equipment (if any)

For example: shower chair, hand-held shower, rails, non-slip mat.

Grooming tasks you find difficult or avoid

For example: hair washing or brushing, nails, shaving, oral care.

Eating and drinking, any help needed?

Help to prepare, cut food, bring it to your mouth, or manage swallowing?

Managing medication

How do you remember doses? Any missed doses in the last 2 weeks? What makes it easier or harder?

Self-care skipped, or accidents because it was too hard

Skipping showers, meals, or medication due to pain, fatigue, or low mood.

SECTION 1.8

Household tasks and admin

QUESTIONS YOUR ANSWERS

Meal preparation and cooking

What you can manage on your own, what is too hard or unsafe, and how often you cook.

Groceries and shopping

Can you plan, travel, shop, and bring things home? What makes this hard?

Cleaning and laundry

Which parts you can do, and which are too hard, e.g. vacuuming, mopping, lifting, bending.

Admin, bills, and tenancy tasks

Paying bills, reading letters, responding to emails, organising repairs.

Any missed bills or tenancy concerns in the last 3 to 6 months?

If yes, briefly describe what happened.

You've done the practical questions. The rest of Part 1 has a few tick-box grids. Save first if you'd like a break.

SECTION 1.9

Work, study, and participation

QUESTIONS YOUR ANSWERS

Current work or study situation

Working, not working, on leave, studying, job-seeking.

Main barriers to working or studying the way you would like

Pain, fatigue, memory, anxiety, transport, sensory overload.

Supports or adjustments that help most at work or study

Flexible hours, quiet space, written instructions, extra breaks.

Social life and friendships

What helps you stay connected? What makes friendships or social time hard?

Community activities

Groups, hobbies, religious or cultural activities. What stops you going or staying?

How long can you usually stay at an event before symptoms force you to leave?

Minutes or hours. An estimate is fine.

Who is giving the ratings in the next section?

A support person can read the questions, explain them, or type for you. If someone needs to answer from their own knowledge of you instead, ask us for the proxy version of this form.

- ◯ I am answering for myself
- ◯ Someone is helping me, but the ratings are mine

WHODAS 2.0, difficulties in the last 30 days

A recognised way to capture how much difficulty you have had with everyday activities over the past 30 days, across thinking, getting around, self-care, getting along with people, daily responsibilities, and taking part in life. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Answer for the past 30 days, thinking of how much difficulty you had while using your usual aids, supports, or help. Rate each from 0 None to 4 Extreme or cannot do.

Please complete every applicable item using the instructions above. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

Cognition, understanding and communicating

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
Concentrating on doing something for ten minutes	○	○	○	○	○
Remembering to do important things	○	○	○	○	○
Analysing and finding solutions to problems in day-to-day life	○	○	○	○	○
Learning a new task, for example, learning how to get to a new place	○	○	○	○	○
Generally understanding what people say	○	○	○	○	○

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
Starting and maintaining a conversation	○	○	○	○	○

Mobility, getting around

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
Standing for long periods such as 30 minutes	○	○	○	○	○
Standing up from sitting down	○	○	○	○	○
Moving around inside your home	○	○	○	○	○
Getting out of your home	○	○	○	○	○
Walking a long distance such as a kilometre	○	○	○	○	○

Self-care

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
Washing your whole body	○	○	○	○	○
Getting dressed	○	○	○	○	○
Eating	○	○	○	○	○
Staying by yourself for a few days	○	○	○	○	○

Getting along with people

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
Dealing with people you do not know	○	○	○	○	○
Maintaining a friendship	○	○	○	○	○
Getting along with people who are close to you	○	○	○	○	○
Making new friends	○	○	○	○	○
Sexual activities	○	○	○	○	○

Life activities, household

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
Taking care of your household responsibilities	○	○	○	○	○
Doing your most important household tasks well	○	○	○	○	○
Getting all the household work done that you needed to do	○	○	○	○	○
Getting your household work done as quickly as needed	○	○	○	○	○

During the past 30 days, did you work, including paid, unpaid or self-employed work, or attend school or study?

If Yes, please complete the four work or study items below. If No, skip them and continue to Participation in society.

○ Yes ○ No

Life activities, work or study (only if you answered Yes above)

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
Your day-to-day work or study	○	○	○	○	○
Doing your most important tasks well	○	○	○	○	○
Getting all the work done that you need to do	○	○	○	○	○
Getting your work done as quickly as needed	○	○	○	○	○

Participation in society

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	○	○	○	○	○

	0 None	1 Mild	2 Moderate	3 Severe	4 Extreme/ cannot do
How much of a problem did you have because of barriers or hindrances in the world around you?	○	○	○	○	○
How much of a problem did you have living with dignity because of the attitudes and actions of others?	○	○	○	○	○
How much time did you spend on your health condition or its consequences?	○	○	○	○	○
How much have you been emotionally affected by your health condition?	○	○	○	○	○
How much has your health been a drain on the financial resources of you or your family?	○	○	○	○	○
How much of a problem did your family have because of your health problems?	○	○	○	○	○
How much of a problem did you have in doing things by yourself for relaxation or pleasure?	○	○	○	○	○

WHODAS, anything else you want us to know?

You can give examples or explain any ratings that were hard to choose.

COPM, your priority activities

List up to three everyday activities that are important to you but difficult to do in the way you want. One or two is also fine. Focus on activities you personally need or want to do, rather than the name of a therapy or service. We confirm these together at your interview.

For example: preparing an evening meal, showering consistently, travelling to appointments, managing the morning routine, completing household cleaning, taking part in a community activity, keeping contact with friends, or managing study tasks. Choose the activity itself, rather than a service like occupational therapy, counselling, a support worker, or more NDIS funding.

Priority activity #1

Describe Priority Activity #1

An everyday activity important to you but hard to do the way you want.

Which life area best fits Priority #1?

- ○ Self-care
- ○ Productivity
- ○ Leisure

Importance

1 Not important — 10 Extremely important

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Performance

1 Very poor — 10 Performs very well

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Satisfaction

1 Not satisfied — 10 Very satisfied

1 2 3 4 5 6 7 8 9 10

When and where does this activity happen? (#1)

Where, how often, what time, with who?

What gets in the way? (#1)

Sensory overload, pain, fatigue, steps, memory, confidence, mood.

What helps? (#1)

Supports, people, tools, routines, or strategies that make it easier or safer.

A small win for Priority #1 would look like...

A realistic improvement over the next 12 weeks.

Priority activity #2

Describe Priority Activity #2

An everyday activity important to you but hard to do the way you want.

Which life area best fits Priority #2?

- Self-care
- Productivity
- Leisure

Importance

1 Not important — 10 Extremely important

1 2 3 4 5 6 7 8 9 10

Performance

1 Very poor — 10 Performs very well

1 2 3 4 5 6 7 8 9 10

Satisfaction

1 Not satisfied — 10 Very satisfied

1 2 3 4 5 6 7 8 9 10

When and where does this activity happen? (#2)

Where, how often, what time, with who?

What gets in the way? (#2)

Sensory overload, pain, fatigue, steps, memory, confidence, mood.

What helps? (#2)

Supports, people, tools, routines, or strategies that make it easier or safer.

A small win for Priority #2 would look like...

A realistic improvement over the next 12 weeks.

Priority activity #3

Describe Priority Activity #3

An everyday activity important to you but hard to do the way you want.

Which life area best fits Priority #3?

- ○ Self-care
- ○ Productivity
- ○ Leisure

Importance

1 Not important — 10 Extremely important

1 2 3 4 5 6 7 8 9 10

Performance

1 Very poor — 10 Performs very well

1 2 3 4 5 6 7 8 9 10

Satisfaction

1 Not satisfied — 10 Very satisfied

1 2 3 4 5 6 7 8 9 10

When and where does this activity happen? (#3)

Where, how often, what time, with who?

What gets in the way? (#3)

Sensory overload, pain, fatigue, steps, memory, confidence, mood.

What helps? (#3)

Supports, people, tools, routines, or strategies that make it easier or safer.

A small win for Priority #3 would look like...

A realistic improvement over the next 12 weeks.

SECTION 1.10

Carer or support person section (optional)

QUESTIONS YOUR ANSWERS

For family members or informal carers who provide regular unpaid support. If this is not you, skip to the final questions. The Zarit carer questionnaire (ZBI-12) is in Part 3's optional measures, if it applies to you.

As a carer or support person, what does your week usually look like?

What you help with, how often, and how it affects your own health, work, or family.

What are your biggest worries or stresses at the moment?

Burnout, health, finances, safety, or anything else that feels important.

Is there anything else you'd like us to know about your caring role?

Any risks, breaks you need, or what support would make the biggest difference.

SECTION 1.11

Final questions

QUESTIONS YOUR ANSWERS

Top 3 priorities for the next 3 months

Up to three things you would like OT and supports to focus on first.

Anything else you want us to know?

Short notes about medication, other therapies, reports you have, or anything we did not ask.

PART 2

PART 2 OF 3

Your story, in your own words

This is where I most want to hear from you, in your own words. Write as much or as little as you like, dot points are welcome, and skip anything you would rather not put down.

WHAT'S IN THIS PART

Open questions about what daily life is really like: your good and hard days, safety and past experiences, the people who support you, and what you'd want your OT and an NDIS planner to understand.

This part is all free writing, and you choose which questions to answer, so it moves at whatever pace suits you. Every box scrolls, so write as much as you like.

You can stop and save at any time. Taking a break here and coming back later is a good idea.

Choose what matters most

You do not need to answer every question. Pick the ones that best show me what daily life is really like for you, and leave the rest. Detailed real-life examples help us prepare an accurate and useful Functional Capacity Assessment. Short answers, long answers and dot points are all welcome. You do not need to repeat information you have already provided. If an earlier answer already covers a question, you may write 'see earlier answer' and add only anything new.

What does a good day look like for you, from waking up to bedtime?

A simple timeline or dot points are fine.

What does a hard day look like, from waking up to bedtime?

How symptoms show up, what you cannot do, what you cancel or change.

Are there certain times of day or days of the week that are always harder?

Mornings, late afternoons, weekends, school days, after appointments or social events.

Two or three big turning points in your health or daily life over recent years?

Diagnoses, injuries, burnout, hospital stays, moving house, relationship changes, job loss.

What do other people usually not see or understand about how hard things are for you?

Invisible symptoms, the effort small tasks take, how long it takes to recover.

Self-care, one or two real-life examples.

Times you skipped showering, could not wash hair, forgot medication, or needed much more help.

Home and household tasks, one or two examples.

Cleaning, cooking, laundry, shopping, or home safety tasks that are difficult, unsafe, or left undone.

Community and appointments, one or two examples.

Getting to shops, appointments, social events, or public places hard or impossible without support.

Thinking, memory, and admin, one or two examples.

Missing appointments, bill mix-ups, things on the stove, getting lost, struggling with forms.

Mood, anxiety, and burnout, how does this look day to day?

Motivation, getting started, leaving the house, sleep, appetite, relationships.

Pain, one or two days that show how it affects what you can and cannot do.

What happens if you push through, and how long it takes to recover.

Fatigue, what does tired mean for you?

Cannot get dressed, cannot stand to cook, cannot think clearly, need to lie down.

Sleep, how does your sleep pattern affect your days?

Trouble falling asleep, waking through the night, waking unrefreshed, naps, insomnia.

Sensory and social load, what pushes you towards overwhelm?

Noise, light, crowds, smells, textures, social situations, phone calls, conflict, changes to plans.

When you become overwhelmed, what usually happens?

Shutdowns, meltdowns, going quiet, dissociation, panic, big emotions, or needing to escape.

That's the picture of your daily life. The next questions are about safety, support, and your report. Save, and continue when you're ready.

Masking or pushing through, does this sound like you?

If yes, what happens before, during, and after? How do you feel later?

Any past stresses or difficult experiences you'd like us to be aware of?

Keep it general if you prefer. You do not need to share details.

What helps you feel safe and respected during appointments or support?

Pace, clear explanations, a support person, being believed, choices, breaks, cultural or spiritual needs.

Are there places you avoid because they feel unsafe, overwhelming, or triggering?

Supermarkets, public transport, shopping centres, school, certain clinics.

Are there types of people or interactions that are especially hard for you?

Authority figures, phone calls, strangers, crowded services, being rushed, conflict.

What helps you feel calmer or more grounded after a difficult event?

Routines, quiet spaces, music, sensory tools, movement, pets, trusted people.

Any accidents or injuries in the last one to two years linked to your health or disability?

Falls, burns, car incidents, medication errors, or self-neglect.

Any near misses where you thought, that could have gone very badly?

Nearly falling or crashing, leaving the stove on, near overdoses, or nearly passing out. Even if you counted these in Part 1, tell the story here.

Are there things you avoid because you are worried they are unsafe to do alone?

Showering, sharp knives, driving, certain outings, cleaning, or lifting.

What safety supports or equipment do you wish you had?

Rails, shower chair, personal alarm, better lighting, safer flooring, medication setup, someone with you.

Have there been times you did not seek medical help even when you probably needed it?

Anxiety, past experiences, access, cost, fear of not being believed, or shame.

Have family, friends, or workers raised worries about your safety?

Falls, driving, cooking, medication, self-neglect, or leaving the house.

Who supports you most in your day-to-day life, and what do they help with?

You listed people in Part 1. Here, tell us who carries the most, and what they actually do.

What do you worry would happen if this support was not available, even for a short time?

Safety, health, mental health, housing, finances, isolation, or tasks not being done.

Are family or friends doing things that feel more like support worker duties than family life?

Personal care, heavy cleaning, complex admin, behaviour support, or constant supervision.

Are there times you avoid asking for help because you do not want to be a burden?

If yes, what happens then?

If you are a carer, how has supporting this person changed your own life?

Work, sleep, health, social life, finances, parenting, or relationships.

Are there signs that your caring role is becoming too heavy or hard to keep up?

Burnout, health problems, exhaustion, feeling trapped, not enough breaks.

What kinds of support would help you as a carer to keep going safely?

Respite, extra support workers, regular breaks, counselling, practical help, clearer plans, crisis backup.

Already covered this? Refer to your earlier answer and add only new information.

If your supports were working really well, what would your week look like in 12 months?

A realistic better version of your week, including energy, safety, and participation.

What kind of help with daily tasks would take the most pressure off you?

Cleaning, laundry, shopping, cooking, personal care, or organising your home.

What kind of therapy or capacity-building support would you find most helpful?

OT, psychology, social work, coaching for routines, sensory strategies, building confidence.

If there was one change that would make your life safer, what would it be?

Falls, self-neglect, medical risk, emotional safety, or your home environment.

Have you tried supports in the past that did not work well for you?

Too rushed, not trauma-informed, not accessible, not the right fit.

Have you tried supports that did help, but stopped or were too short-term?

What changed when you had them? What was lost when they stopped?

If you could design your ideal support worker, what would they be like?

Personality, communication, cultural understanding, lived experience, language, gender, age, interests.

Anything you want to make sure your OT includes or understands when writing your report?

Key messages, non-negotiables, or important context.

If an NDIS planner could understand just three things about your life, what would they be?

How hard you are trying, how limited your energy is, how unsafe things feel without support.

How would you like to be described in your report?

Strengths, values, the way you keep going, what you care about.

Are there words or descriptions you do not want used about you?

Labels or phrases that feel blaming, shaming, or inaccurate. We will avoid these.

Last questions: anything else you want us to know?

Extra notes about medical issues, therapies, supports, or experiences we have not covered.

PART 3

PART 3 OF 3

Standardised measures and Seeds profiles

Recognised questionnaires and our own Seeds profiles. A short guide partway through tells you which of the optional measures apply to you, and each section opens with a note explaining what it is and why I ask.

WHAT'S IN THIS PART

Seeds profiles first: quick tick-boxes covering attention and organisation, daily living, support needs, participation, and support intensity. Then a short guide to the optional recognised questionnaires (WSAS, PSS-10, DASS-21, ZBI-12, RAND-36) and the home environment profile, so you complete only the sections that fit your circumstances.

It looks long, but it is almost all ticking boxes, and the guide means most people skip some sections entirely.

You can stop and save at any time. Taking a break here and coming back later is a good idea.

Before you start

This part has two halves. First come the Seeds profiles, quick tick-box sections that help round out the picture of daily life. Fill in the ones that apply to you. Then a short guide helps you choose which of the recognised questionnaires match your circumstances, and you complete only those. Some of this covers ground you have already touched on in Parts 1 and 2. That is deliberate, and in these tick-box sections it is fine to repeat yourself. I have left your goals out of this part, since we covered those together in Part 1.

Seeds Attention and Organisation Profile

A Seeds OT clinical profile of the areas that attention, organisation, and impulse difficulties tend to touch. It is interpreted descriptively and does not produce a standardised score. Rate each from 0 Never to 3 Very often. Use N/A if it does not apply.

Complete this profile when it reflects an important part of your daily functioning. Otherwise, you may skip it.

Family

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Problems getting along with family members	○	○	○	○	○
Arguments or fights at home	○	○	○	○	○
Trouble keeping family rules	○	○	○	○	○
Causing stress to family	○	○	○	○	○
Relying on others too much for help at home	○	○	○	○	○
Parents or partner upset with your behaviour	○	○	○	○	○
Difficulty completing chores or household responsibilities	○	○	○	○	○
Forgetting obligations or promises	○	○	○	○	○

Work or school

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Problems completing assignments or tasks	○	○	○	○	○
Missing deadlines	○	○	○	○	○
Being disorganised	○	○	○	○	○

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Forgetting instructions	○	○	○	○	○
Difficulty starting work	○	○	○	○	○
Losing materials or tools needed for work	○	○	○	○	○
Arriving late or missing work or school	○	○	○	○	○
Problems with a supervisor or teacher because of behaviour or performance	○	○	○	○	○

Life skills

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Trouble managing money or paying bills	○	○	○	○	○
Forgetting appointments	○	○	○	○	○
Being late for appointments	○	○	○	○	○
Difficulty keeping track of time	○	○	○	○	○
Forgetting to take medication	○	○	○	○	○
Poor personal hygiene	○	○	○	○	○
Difficulty preparing meals	○	○	○	○	○

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Trouble maintaining a home	○	○	○	○	○

How you see yourself

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Feeling bad about yourself	○	○	○	○	○
Feeling you are not meeting your potential	○	○	○	○	○
Feeling disappointed in yourself	○	○	○	○	○
Others criticise you for not trying hard enough	○	○	○	○	○

Social

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Problems making or keeping friends	○	○	○	○	○
Saying or doing things you later regret	○	○	○	○	○
Difficulty in group conversations	○	○	○	○	○
Interrupting others or talking too much	○	○	○	○	○
Difficulty listening to others	○	○	○	○	○

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Avoiding social activities	○	○	○	○	○
Feeling lonely or left out	○	○	○	○	○

Risk

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Acting without thinking	○	○	○	○	○
Doing things that get you into trouble	○	○	○	○	○
Driving too fast or unsafely	○	○	○	○	○
Drinking alcohol excessively	○	○	○	○	○
Using drugs or medications inappropriately	○	○	○	○	○
Getting into fights or arguments	○	○	○	○	○
Spending too much money impulsively	○	○	○	○	○
Engaging in risky sexual behaviour	○	○	○	○	○
Taking unnecessary risks	○	○	○	○	○
Breaking rules or laws	○	○	○	○	○

	0 Never	1 Some-times	2 Often	3 Very often	N/A
Doing things that could harm yourself or others	○	○	○	○	○
Getting injured because of impulsivity	○	○	○	○	○
Problems caused by anger	○	○	○	○	○
Losing your temper	○	○	○	○	○
Saying things you later regret because of anger	○	○	○	○	○

Seeds Daily Living Profile

A Seeds OT clinical profile, a short check of everyday living and self-care, interpreted descriptively. Answer for how things usually are. How much difficulty do you have with each?

Complete this profile when it reflects an important part of your daily functioning. Otherwise, you may skip it.

	No difficulty	Some	Moderate	Extreme
Looking after yourself	○	○	○	○
Handling money responsibly	○	○	○	○
Keeping an adequate diet	○	○	○	○
Completing everyday household tasks	○	○	○	○

	No difficulty	Some	Moderate	Extreme
Keeping socially appropriate behaviour	○	○	○	○
Keeping a stable living arrangement	○	○	○	○
Communicating effectively with others	○	○	○	○
Keeping contact with family or friends	○	○	○	○
Behaving in a way that is not troublesome to others	○	○	○	○
Taking prescribed medication as directed	○	○	○	○
Coping with day-to-day stress	○	○	○	○
Acting responsibly in public	○	○	○	○
Travelling independently when needed	○	○	○	○
Keeping appointments reliably	○	○	○	○
Showing initiative in daily activities	○	○	○	○
Generally behaving predictably and safely	○	○	○	○

Seeds IADL Support Profile

A Seeds OT clinical profile of the more complex tasks of living independently, interpreted descriptively. Answer for a typical week. How much help do you need with each?

Complete this profile when it reflects an important part of your daily functioning. Otherwise, you may skip it.

	Independent	Some help	A lot of help	Cannot do
Using the telephone	○	○	○	○
Shopping	○	○	○	○
Preparing food	○	○	○	○
Housekeeping	○	○	○	○
Laundry	○	○	○	○
Getting around or transport	○	○	○	○
Managing your medication	○	○	○	○
Managing finances	○	○	○	○

Seeds ADL Support Profile

A Seeds OT clinical profile of the basic self-care tasks most days are built around, interpreted descriptively. Answer for an average day. How much help do you need with each?

Complete this profile when it reflects an important part of your daily functioning. Otherwise, you may skip it.

	Independent	A little help	A lot of help	Fully dependent
Feeding	○	○	○	○
Bathing	○	○	○	○
Grooming	○	○	○	○
Dressing	○	○	○	○
Bowels	○	○	○	○
Bladder	○	○	○	○
Using the toilet	○	○	○	○
Moving from bed to chair and back	○	○	○	○
Moving on level surfaces	○	○	○	○
Stairs	○	○	○	○

Participation and community

A few questions about who does what at home and how often you get out and take part in life around you. Just describe how things actually are.

Who usually prepares meals in your household?

- ○ Mostly me
- ○ Shared
- ○ Mostly someone else

Who usually does the daily housework?	◯ Mostly me ◯ Shared ◯ Mostly someone else
Who usually does the grocery or household shopping?	◯ Mostly me ◯ Shared ◯ Mostly someone else
Who usually looks after the finances?	◯ Mostly me ◯ Shared ◯ Mostly someone else
Do you have a driver's licence?	◯ Yes ◯ No ◯ Suspended or expired
Do you drive regularly?	◯ Yes ◯ No
How often do you travel outside your home?	◯ Often ◯ Sometimes ◯ Rarely ◯ Never
How often do you visit friends or relatives in their home?	◯ Often ◯ Sometimes ◯ Rarely ◯ Never
How often do they visit you in your home?	◯ Often ◯ Sometimes ◯ Rarely ◯ Never
How often do you go shopping, to movies, restaurants, or sport?	◯ Often ◯ Sometimes ◯ Rarely ◯ Never

How often do you take part in leisure activities outside home?

- ○ Often
- ○ Sometimes
- ○ Rarely
- ○ Never

Are you currently employed or studying?

- ○ Yes
- ○ No

If yes, how many hours per week?

How satisfied are you with your community involvement?

0 Not satisfied — 10 Very satisfied

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Seeds Participation and Community Profile

A Seeds OT clinical profile exploring participation and community involvement. It is interpreted descriptively and does not produce a standardised score. Compared with others your age, how much of a problem is each for you? Tick 'Not relevant / no restriction' if it does not apply to your life.

Complete this profile when it reflects an important part of your daily functioning. Otherwise, you may skip it.

	Not relevant / no restriction	No problem	Small	Medium	Large
Having the same opportunity to work as your peers	○	○	○	○	○
Working as hard as your peers (hours, type of work)	○	○	○	○	○
Contributing to the household economically like your peers	○	○	○	○	○

	Not relevant / no restriction	No problem	Small	Medium	Large
Getting out and about as much as your peers	○	○	○	○	○
Taking part in major festivals and events as your peers do	○	○	○	○	○
Taking part in casual social or recreational activities	○	○	○	○	○
Being as socially active in community life as your peers	○	○	○	○	○
Having the same respect in the community as your peers	○	○	○	○	○
Caring for yourself (appearance, nutrition, health) as well as peers	○	○	○	○	○
Same chance to start or keep a long-term relationship	○	○	○	○	○
Visiting other people in the community as often as others	○	○	○	○	○
Moving around your home and neighbourhood like others	○	○	○	○	○
Visiting public places as often as others (shops, offices)	○	○	○	○	○
Doing household work in your home	○	○	○	○	○
Having your opinion count in family discussions	○	○	○	○	○

	Not relevant / no restriction	No problem	Small	Medium	Large
Helping other people (neighbours, friends, relatives)	○	○	○	○	○
Feeling comfortable meeting new people	○	○	○	○	○
Feeling confident to try to learn new things	○	○	○	○	○

Seeds Support Intensity Profile

A Seeds OT clinical profile of the level of support needed across five areas of life, interpreted descriptively. For each area, what level of support do you need?

Complete this profile when it reflects an important part of your daily functioning. Otherwise, you may skip it.

	Indepen-dent	Some support	Daily support	Constant support	24-hour
Self-care	○	○	○	○	○
Domestic tasks	○	○	○	○	○
Getting around the community or transport	○	○	○	○	○
Work, study, or productivity	○	○	○	○	○
Safety and judgement	○	○	○	○	○

That's the Seeds profiles done. Next, a short guide to the optional questionnaires, so you only complete the ones that apply to you. Save if you'd like a break.

SECTION 3.1

Which additional sections should I complete?

QUESTIONS YOUR ANSWERS

How this works

Everyone completes the main intake, the WHODAS section, and the occupational priorities. The measures below are additional. Complete only the sections that match your circumstances, or that Seeds Occupational Therapy has asked you to complete. You do not need to complete every measure. Answer Yes or No for each one below, then complete only the sections you marked Yes. Each has a link that takes you straight to it, and every section has a link back to this guide.

WSAS, Work and Social Adjustment Scale

Will you complete the WSAS?

Complete it if a health condition substantially affects work or study, home management, social activities, private leisure, or close relationships.

◯ Yes ◯ No

Go to WSAS · page 59 →

PSS-10, Perceived Stress Scale

Will you complete the PSS-10?

Complete it if stress, overload, unpredictability, or difficulty coping is an important part of your current situation.

◯ Yes ◯ No

Go to PSS-10 · page 61 →

DASS-21, Depression Anxiety Stress Scales

Will you complete the DASS-21?

Complete it if depression, anxiety, or stress symptoms are an important part of this assessment.

◯ Yes ◯ No

Go to DASS-21 · page 63 →

ZBI-12, Zarit Burden Interview

Will your carer complete the ZBI-12?

For carers. Complete it if an unpaid family member, partner, or friend provides regular care or support. The carer answers it from their own perspective.

◯ Yes ◯ No

Go to ZBI-12 · page 66 →

RAND-36, health and functioning

Will you complete the RAND-36?

Complete it if broad physical health, pain, fatigue, or health-related day-to-day functioning is a major part of this assessment.

◯ Yes ◯ No

Go to RAND-36 · page 68 →

Seeds Home Environment Profile

Will you complete the home environment profile?

Complete it if falls, transfers, stairs, bathroom access, home access, or hazards around your home are relevant.

◯ Yes ◯ No

Go to Seeds Home Environment Profile · page 75 →

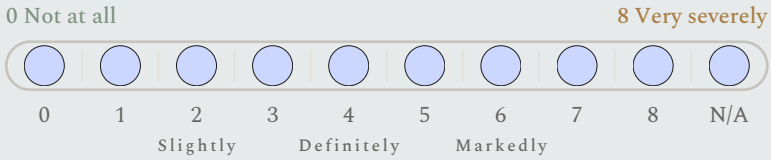
WSAS, Work and Social Adjustment Scale

Complete this section only if you marked Yes in the guide; otherwise skip the whole section. These five ask how much your health gets in the way of ordinary life: work, running a home, time with others, time for yourself, and close relationships. Look at each area and rate how much your problem impairs your ability to carry out the activity, where 0 means not at all impaired and 8 means very severely impaired.

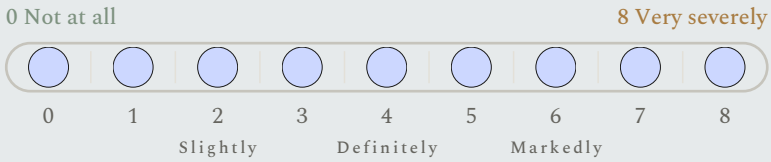
If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

Work or study

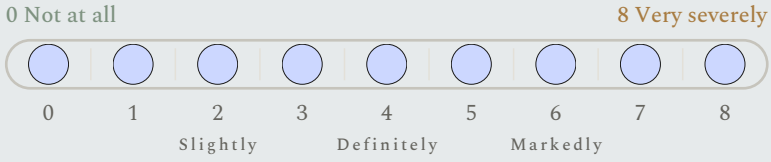
If you are not working or studying, tick N/A.



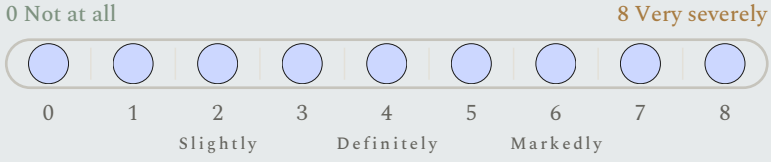
Home management (cleaning, tidying, shopping, cooking, looking after home or children, paying bills)



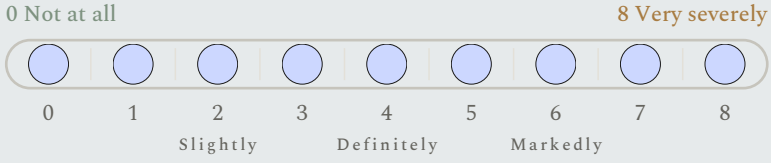
Social leisure activities (with other people: parties, outings, visits, dating, entertaining)



Private leisure activities (done alone: reading, gardening, hobbies, walking)



Close relationships (forming and keeping close relationships, including those you live with)



← Return to the optional-section guide

PSS-10, Perceived Stress Scale

Complete this section only if you marked Yes in the guide; otherwise skip it. This asks how unpredictable, uncontrollable, and stretched life has felt over the last month. There are no right answers, just how it has felt for you. In the last month, how often have you…

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	0 Never	1 Almost never	2 Some-times	3 Fairly often	4 Very often
Been upset because of something that happened unexpectedly	○	○	○	○	○
Felt that you were unable to control the important things in your life	○	○	○	○	○
Felt nervous and stressed	○	○	○	○	○
Felt confident about your ability to handle your personal problems	○	○	○	○	○
Felt that things were going your way	○	○	○	○	○
Found that you could not cope with all the things that you had to do	○	○	○	○	○
Been able to control irritations in your life	○	○	○	○	○

	0 Never	1 Almost never	2 Some-times	3 Fairly often	4 Very often
Felt that you were on top of things	○	○	○	○	○
Been angered because of things that were outside of your control	○	○	○	○	○
Felt difficulties were piling up so high that you could not overcome them	○	○	○	○	○

← Return to the optional-section guide

DASS-21, Depression Anxiety Stress Scales

Complete this section only if you marked Yes in the guide; otherwise skip it. These questions ask about low mood, anxiety, and stress over the past week. They help put a recognised number to feelings that are otherwise hard to describe. Read each statement and pick the number which indicates how much the statement applied to you over the past week. There are no right or wrong answers. 0 Did not apply to me at all. 1 Applied to me to some degree, or some of the time. 2 Applied to me to a considerable degree, or a good part of time. 3 Applied to me very much, or most of the time.

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	0 Did not apply	1 Some of the time	2 A good part	3 Most of the time
I found it hard to wind down	○	○	○	○
I was aware of dryness of my mouth	○	○	○	○
I couldn't seem to experience any positive feeling at all	○	○	○	○
I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	○	○	○	○
I found it difficult to work up the initiative to do things	○	○	○	○
I tended to over-react to situations	○	○	○	○

	0 Did not apply	1 Some of the time	2 A good part	3 Most of the time
I experienced trembling (eg, in the hands)	○	○	○	○
I felt that I was using a lot of nervous energy	○	○	○	○
I was worried about situations in which I might panic and make a fool of myself	○	○	○	○
I felt that I had nothing to look forward to	○	○	○	○
I found myself getting agitated	○	○	○	○
I found it difficult to relax	○	○	○	○
I felt down-hearted and blue	○	○	○	○
I was intolerant of anything that kept me from getting on with what I was doing	○	○	○	○
I felt I was close to panic	○	○	○	○
I was unable to become enthusiastic about anything	○	○	○	○
I felt I wasn't worth much as a person	○	○	○	○
I felt that I was rather touchy	○	○	○	○

	0 Did not apply	1 Some of the time	2 A good part	3 Most of the time
I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	○	○	○	○
I felt scared without any good reason	○	○	○	○
I felt that life was meaningless	○	○	○	○

← Return to the optional-section guide

Zarit Burden Interview, Short Form (ZBI-12)

Complete this section only if you marked Yes in the guide; otherwise skip it. It is completed by the carer or support person, from their own perspective. These are the twelve questions of the Zarit Burden Interview short form, a recognised measure of carer strain. 'Your relative' means the person you care for. For each question, tick how often you feel that way: 0 Never, 1 Rarely, 2 Sometimes, 3 Quite frequently, 4 Nearly always.

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	0 Never	1 Rarely	2 Sometimes	3 Quite frequently	4 Nearly always
Do you feel that because of the time you spend with your relative that you don't have enough time for yourself?	○	○	○	○	○
Do you feel stressed between caring for your relative and trying to meet other responsibilities for your family or work?	○	○	○	○	○
Do you feel angry when you are around your relative?	○	○	○	○	○
Do you feel that your relative currently affects your relationship with family members or friends in a negative way?	○	○	○	○	○
Do you feel strained when you are around your relative?	○	○	○	○	○

	0 Never	1 Rarely	2 Sometimes	3 Quite frequently	4 Nearly always
Do you feel that your health has suffered because of your involvement with your relative?	○	○	○	○	○
Do you feel that you don't have as much privacy as you would like because of your relative?	○	○	○	○	○
Do you feel that your social life has suffered because you are caring for your relative?	○	○	○	○	○
Do you feel that you have lost control of your life since your relative's illness?	○	○	○	○	○
Do you feel uncertain about what to do about your relative?	○	○	○	○	○
Do you feel you should be doing more for your relative?	○	○	○	○	○
Do you feel you could do a better job in caring for your relative?	○	○	○	○	○

← Return to the optional-section guide

General health and physical functioning (RAND-36)

Complete this section only if you marked Yes in the guide; otherwise skip the whole section. First your overall sense of your health, then a set about activities you might do during a typical day, and whether your health now limits you in them.

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is…	○	○	○	○	○

Compared to one year ago, how would you rate your health in general now?

- ○ Much better now than one year ago
- ○ Somewhat better now than one year ago
- ○ About the same
- ○ Somewhat worse now than one year ago
- ○ Much worse now than one year ago

Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	○	○	○

	Yes, limited a lot	Yes, limited a little	No, not limited at all
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
Lifting or carrying groceries	○	○	○
Climbing several flights of stairs	○	○	○
Climbing one flight of stairs	○	○	○
Bending, kneeling, or stooping	○	○	○
Walking more than one kilometre	○	○	○
Walking half a kilometre	○	○	○
Walking one hundred metres	○	○	○
Bathing or dressing yourself	○	○	○

RAND-36, role limits due to physical health

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? Answer Yes or No for each.

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	Yes	No
Cut down the amount of time you spent on work or other activities	○	○
Accomplished less than you would like	○	○
Were limited in the kind of work or other activities	○	○
Had difficulty performing the work or other activities (for example, it took extra effort)	○	○

RAND-36, role limits due to emotional problems

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems, such as feeling depressed or anxious? Answer Yes or No for each.

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	Yes	No
Cut down the amount of time you spent on work or other activities	○	○
Accomplished less than you would like	○	○

	Yes	No
Didn't do work or other activities as carefully as usual	○	○

RAND-36, social functioning and pain

A few questions about how much health or pain has got in the way of your social life and usual activities.

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	Not at all	Slightly	Moderately	Quite a bit	Extremely
During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups?	○	○	○	○	○

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities, like visiting with friends or relatives?	○	○	○	○	○

	None	Very mild	Mild	Moderate	Severe	Very severe
How much bodily pain have you had during the past 4 weeks?	○	○	○	○	○	○

	Not at all	A little bit	Moderately	Quite a bit	Extremely
During the past 4 weeks, how much did pain interfere with your normal work, including both work outside the home and housework?	○	○	○	○	○

RAND-36, emotional wellbeing

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks…

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Have you been a very nervous person?	○	○	○	○	○	○
Have you felt so down in the dumps that nothing could cheer you up?	○	○	○	○	○	○
Have you felt calm and peaceful?	○	○	○	○	○	○
Have you felt downhearted and blue?	○	○	○	○	○	○
Have you been a happy person?	○	○	○	○	○	○

RAND-36, energy and fatigue

Continuing the same set: give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks…

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of life?	○	○	○	○	○	○
Did you have a lot of energy?	○	○	○	○	○	○
Did you feel worn out?	○	○	○	○	○	○
Did you feel tired?	○	○	○	○	○	○

RAND-36, general health views

How true or false is each of the following statements for you?

If you are completing this set, please answer every item in it, because each item forms part of the result. If you are unsure between two responses, choose the response that best reflects your usual experience during the stated timeframe.

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
I seem to get sick a little easier than other people	○	○	○	○	○

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
I am as healthy as anybody I know	○	○	○	○	○
I expect my health to get worse	○	○	○	○	○
My health is excellent	○	○	○	○	○

← Return to the optional-section guide

Seeds Home Environment Profile

Complete this section only if you marked Yes in the guide; otherwise skip it. A Seeds OT clinical profile of safety around your home, interpreted descriptively. Each item is worded so that Yes means safe. Answer Yes, No, or N/A. Leaving an item blank means it is unanswered, not safe.

Complete this profile when it reflects an important part of your daily functioning. Otherwise, you may skip it.

	Yes (safe)	No (hazard)	N/A
Non-slip surface in the shower or bath	○	○	○
Grab rails in the bathroom	○	○	○
Can step over the bath edge safely	○	○	○
Shower screen or door is easy to use	○	○	○
Toilet is a comfortable height	○	○	○
Rails near the toilet	○	○	○
Toilet is within easy reach of the bedroom	○	○	○
Mats and rugs are secure or removed	○	○	○
Floors are clear of clutter and cords	○	○	○

	Yes (safe)	No (hazard)	N/A
Floor surfaces are non-slip	○	○	○
Flooring is even	○	○	○
Handrail on steps or stairs	○	○	○
Steps are in good repair	○	○	○
Step edges are easy to see	○	○	○
Non-slip on steps	○	○	○
Usually wears supportive footwear indoors	○	○	○
Footwear is well-fitting and in good condition	○	○	○
Mobility aid used as advised	○	○	○
Good lighting in key areas	○	○	○
Light within reach of the bed at night	○	○	○
Light switches are easy to reach	○	○	○
Outdoor paths are even	○	○	○
Outdoor rails where needed	○	○	○

	Yes (safe)	No (hazard)	N/A
Outdoor surfaces are non-slip when wet	○	○	○
Good outdoor lighting	○	○	○

Anything else about your home or safety you want to tell us?

← Return to the optional-section guide

WHAT HAPPENS NEXT

What happens next

Once you have finished, here is what to do and what happens on our side.

ONCE YOU HAVE FINISHED

1 Finish the form
Work through it at your own pace and save it to your own computer as you go.

2 Gather your documents
Collect and finalise anything that helps tell your story, up to ten files, ready to send together.

3 Upload it all at once
Upload the form and your documents together using the link we sent you. Sending everything in one go is what lets us begin.

4 We take it from here
Your assessing therapist reads everything personally, and then your assessment goes ahead.

Thank you for trusting me *with your story.*

Questions before you start? nisha@seedsoccupationaltherapy.com.au · 03 7056 9242 · West Footscray, Melbourne

Nisha Bal Principal Occupational Therapist