FUNCTION REPORT – ADULT – Form SSA-3373-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can and call the phone number provided on the letter sent with the form, or contact the person who asked you to complete the form. If you need the address or phone number for the office that provided the form, you can get it by calling Social Security at 1-800-772-1213.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the decision on your disability claim or case. You can help them by completing as much of the form as you can.

It is important that you tell us about your activities and your abilities and about any changes in your activities or your abilities since your illnesses, injuries, or conditions and any related symptoms first bothered you.

- Print or write clearly.
- **DO NOT LEAVE ANSWERS BLANK.** If you do not know the answer or the answer is “none” or “does not apply,” please write “don’t know,” or “none,” or “does not apply.”
- Do not ask a doctor or hospital to complete this form.
- Be sure to consider any symptoms related to your illnesses, injuries, or conditions, such as pain, fatigue, shortness of breath, weakness, or nervousness, when answering questions about how your illnesses, injuries, or conditions affect your activities or abilities.
- When a question refers to “you” or “your,” it refers to the person who is applying for or receiving disability benefits. If you are filling out the report for that person, please provide the information about him or her. Use the space in Section D to explain why the person is not completing the form himself or herself.
- Be sure to explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If you need more space to answer any questions or want to tell us more about an answer, please use the “REMARKS” section, beginning on Page 13 or attach a blank sheet of paper, and show the number of the question being answered. If you do attach a blank sheet of paper, please put your name and Social Security Number at the top of the sheet so that we can make sure we keep the sheet with your claims file.

REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON COMPLETING THIS FORM AND THE DATE THE FORM WAS COMPLETED ON PAGE 14

The Privacy Act

The Social Security Administration is authorized to collect the information on this form under sections 205(a) and (b), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on your claim or case. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on your claim or case. Although the information you furnish is almost never used for any purpose other than making a determination about your disability or continuing disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

The Paperwork Reduction Act

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. If you do not have that address, you may call Social Security at 1-800-772-1213**. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

AFTER COMPLETING THIS FORM, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS.

OMB No. 0960-0681

SOCIAL SECURITY ADMINSTRATION

FUNCTION REPORT – ADULT

SECTION A – GENERAL INFORMATION

1. **NAME OF PERSON APPLYING FOR OR RECEIVING DISABILITY BENEFITS**
(First, Middle, Last)_____

2. **SOCIAL SECURITY NUMBER** ___ - __ - ____

3. **YOUR DAYTIME TELEPHONE NUMBER** (If there is no telephone number where you can be reached, please tell us the name and daytime number of a person with whom we can leave a message for you.)

___ _____ Your Number Message Number None
Area Code Phone Number

_____

4. LIST any symptoms related to your illnesses, injuries, or conditions _____
_____
_____

5. **a**. Do you live in a: (Check where you live **NOW**)

1. House?
2. Apartment?
3. Boarding House?
4. Nursing Home?
5. Shelter?
6. Group Home?
7. Other?

If you checked "**Other**," please **DESCRIBE** where you live _____
_____

b: Do you live (Check your **CURRENT** living arrangement)

1. Alone?
2. With Family?
3. With Friends?
4. Other?

If you checked "**Other**," please **DESCRIBE** your living arrangement _____
_____

c. Has there been any change in where you live or your living arrangements because of your illnesses, injuries, or conditions? YES NO

If "NO," go to **Section B.**

If "YES," please **DESCRIBE** what has changed._____

_____

_____

_____

_____

d. What is the reason for the change? _____

_____

_____

SECTION B – INFORMATION ABOUT YOUR ABILITIES

6. **a.** Do your illnesses, injuries, or conditions affect your ability to:

1. Lift?	YES	NO	**8.** Kneel?	YES	NO
2. Carry?	YES	NO	**9.** Crawl?	YES	NO
3. Stand?	YES	NO	**10.**Reach?	YES	NO
4. Walk?	YES	NO	**11.**Use Your Hands?	YES	NO
5. Sit?	YES	NO	**12.** See?	YES	NO
6. Climb Stairs?	YES	NO	**13.** Hear?	YES	NO
7. Bend?	YES	NO	**14.** Talk?	YES	NO

b. If you checked "YES" for an activity, please **LIST** the number of the activity and **EXPLAIN HOW** and **WHY** your illnesses, injuries, or conditions affect your ability to do that activity. For example, before you were able to lift [how many pounds], but now you can lift [how many pounds] because your shoulder is weak; before you were able to walk [how far], but now you can walk [how far] because you get tired; you used to wear shoes that laced, but now you only wear slip-on shoes because your fingers are too stiff to tie laces. Please be as **SPECIFIC** as you can._____

_____

_____

_____

_____

_____

_____

c. For each of the activities below, please check the box that best describes what you can do

1. I can walk for 0 1 2 3 4 5 6 7 8 hours before having to rest.

2. I can stand for 0 1 2 3 4 5 6 7 8 hours before having to rest.

3. I can sit for 0 1 2 3 4 5 6 7 8 hours before having to change position.

4. I can bend Frequently Occasionally Never

5. I can lift 10 20 30 40 50 pounds frequently

6. I can lift 10 20 30 40 50 pounds occasionally

7. I can reach my arms out and up Frequently Occasionally Never

d. Do you **USE**:

1. Crutches?	YES	NO	**6.** Glasses/Contact Lenses?	YES	NO
2. Cane?	YES	NO	**7.** Hearing Aid?	YES	NO
3. Walker?	YES	NO	**8.** Artificial Arm or Leg?	YES	NO
4. Brace/Splint?	YES	NO	**9.** Artificial Voice Box?	YES	NO
5. Wheelchair?	YES	NO	**10.** Other Assistive Device?	YES	NO

If you checked "YES" to **10**, please **DESCRIBE** the device. _____

_____

_____

e. If you do not use any type of assistive device, go to **g.**

If you use an assistive device, **LIST** each type of assistive device you use, **DESCRIBE** when you use it, and **TELL** if it does or does not help you in your daily activities.

_____

_____

_____

_____

f. If the assistive device(s) was prescribed, **TELL** who prescribed it and the **DATE** it was prescribed._____

_____

_____

_____

g. Have your illnesses, injuries, or conditions affected your ability to:

1. Pay attention?	YES	NO
2. Understand	YES	NO
3. Finish something you start?	YES	NO
4. Read a newspaper, magazine, or book?	YES	NO
5. Watch a movie?	YES	NO
6. Follow written instructions?	YES	NO
7. Follow spoken instructions?	YES	NO
8. Handle changes in your routine?	YES	NO
9. Handle stress?	YES	NO

h. If you checked "YES" for any activity in **g.**, please **LIST** the activity and **EXPLAIN WHAT** has changed because of your illnesses, injuries, or conditions._____

_____

_____

_____

_____

7. MEDICATION, TREATMENT, OR OTHER METHOD

a. Do you take any prescription or non-prescription medications for your illnesses, injuries, conditions, or symptoms? YES NO

If "NO," go to **b.**

If "YES," please answer **1.**, **2.**, and **3**.

1. Do you take the medications in the dosages and at the frequency instructed? YES NO

If "NO," please **EXPLAIN** why not and at **WHAT** dosage and frequency you take the medication. _____

_____

_____

2. Do you need help or reminders to take your medications? YES NO

If "NO," go to **3.**

If "YES," what help or reminders do you need? Please **DESCRIBE.** _____

_____

_____

_____

3. Has the medication affected your ability to do things (for example, after taking your medication you can bend more easily; the medication makes you sleepy)? YES NO

If "NO," go to **b.**

If "YES," please **EXPLAIN** the effect the medication you take for your illnesses, injuries, or conditions has on your ability to do things._____

_____

_____

_____

b. Is there any treatment, other than medication, (for example, acupuncture or physical therapy) or other method (for example, lying flat on your back or changing position) that you use now or that you have used in the past for your illnesses, injuries, conditions or symptoms? YES NO

If "NO," go to **Section C.**

If "YES," please answer **1.**, **2., 3.,** and **4**:

1. For each treatment or other method you use or have used, **LIST** the **TYPE** and the **DATE** you started the treatment or other method and the **DATE** treatment ended. If you are still taking the treatment or using the other method, show "ongoing."_____

_____

_____

_____

2. Was the treatment or other method recommended by a doctor or other health care professional who treated or examined you? YES NO

If "NO," go to **3.**

If "YES," please **LIST** the treatment or other method, the **NAME** of the doctor or other health care professional who recommended it, and **HOW OFTEN** you take the treatment or use the other method._____

_____

_____

_____

3. Do you need help or reminders to follow your treatments or other methods? YES NO

If "NO," go to **4.**

If "YES," what kind of help or reminders do you need? Please **DESCRIBE.** _____

_____

_____

_____

4. Have the treatments or other methods you use or have used affected your ability to do things (for example, changing positions relieves pain in your back; the treatments leave you tired)?

YES NO.

If "NO," go to **Section C.**

If "YES," please **EXPLAIN** the effect the treatments or other methods you use for illnesses, injuries, or conditions have on your ability to do things. Please be **SPECIFIC.**

_____

_____

_____

SECTION C – INFORMATION ABOUT YOUR DAILY ACTIVITIES

8. PERSONAL CARE

a. Do your illnesses, injuries, or conditions affect your ability to:

1. Dress?	YES	NO	**5.** Shave?	YES	NO
2. Shower or bathe?	YES	NO	**6.** Feed yourself?	YES	NO
3. Care for hair?	YES	NO	**7.** Use a toilet?	YES	NO
4. Care for teeth?	YES	NO	**8.** Do some other personal care activity?	YES	NO

b. For each item that you checked "YES," **LIST** the number of the item and **DESCRIBE** how your illnesses, injuries, or conditions affect that activity (for example, it takes more time to dress, you have a simpler hair style, you changed to an electric razor)._____

_____

_____

_____

_____

_____

_____

c. Do you need help or reminders to care for your personal needs? YES NO

If "NO," go to question **9.**

If "YES," what kind of help or reminders do you need? _____

_____

_____

_____

9. Do your illnesses, injuries, or conditions affect your sleep? YES NO

If "NO," go to question **10.**

If "YES," please **EXPLAIN.**

_____

_____

_____

10. Do you take care of:

a. Another person (for example, your spouse, child, grandchild, parent, or friend)?
YES NO NEVER DID THIS

b. A pet or other animal? YES NO NEVER DID THIS

c. If you answered "NO" or "NEVER DID THIS," to **a.** and **b.,** go to question **11.**

If you answered "YES" to **a.** or **b**:

1. Who or what do you take care of? _____

_____

2. What do you do for them? _____

_____

3. Does someone help you take care of the other person, pet or other animal? YES NO

If "NO," go to question **11.**

If "YES," please answer **a**. and **b**.

a. Who helps you? _____

_____

b. How do they help you? _____

_____

_____

11. Has there been any change in what you can do because of your illnesses, injuries, or conditions?
YES NO

If "NO," go to question **12.**

If "YES," please **EXPLAIN.**

_____

_____

12. **GETTING AROUND**

a. Do you go outside your home alone? YES NO

If "YES," go to **b.**

If "NO," please **EXPLAIN** why you do not go out alone._____

_____

_____

_____

b. When you go outside your home, do you (Check **ALL** that apply)

1. Walk?

2. Drive yourself?

3. Go as a passenger in a car, truck, or other private vehicle?

4. Use public transportation?

5. Ride a bicycle?

6. Other?

If you checked "Other' please **DESCRIBE.** _____

_____

_____

c. If you checked **b.2**, please **TELL** how **OFTEN** you drive and how **FAR** you can drive comfortably._____

_____

_____

d. Even if you do not drive yourself when you go outside your home, can you drive?

YES NO

1. If "YES," please **EXPLAIN** why you do not drive yourself when you go outside your home (for example, you do not have a current driver's license)._____

_____

_____

_____

_____

2. If "NO," please **EXPLAIN** why you cannot drive (for example, you never learned how to drive). _____

_____

_____

e. Has there been any change in how you travel to places outside your home (for example, to a doctor, shopping, visiting) because of your illnesses, injuries, or conditions? YES NO

If "NO," go to question **13**

If "YES," please **DESCRIBE** the change._____

_____

_____

_____

13. MONEY

a. Are you able to:

1. Use your money by yourself? YES NO

2. Count change? YES NO

3. Handle a savings account? YES NO

4. Use checks or money orders? YES NO

If you are able to do all of the listed activities, go to **b.**

For any item that you checked "NO," please **EXPLAIN** why you are not able to do the activity. _____

_____

_____

_____

b. Has there been any change in your ability to manage your money or pay your bills because of your illnesses, injuries, or conditions? YES NO

If "NO," go to question **14.**

If "YES," please **DESCRIBE** the change._____

_____

_____

_____

14. **MEALS**

a. Do you prepare your own meals? YES NO

If "YES," go to **b**.

If "NO," please **EXPLAIN** why you do not prepare your own meals._____

_____

_____

_____

b. What meals do you usually prepare? (Check **ALL** that apply)

1. Breakfast **2.** Lunch **3.** Dinner

c. Normally do you (Check the answer that is **MOST OFTEN** true)

1. Order take-out food?

2. Make simple meals, needing little preparation (dry cereal and milk, sandwiches, canned soup)?

3. Use ingredients requiring peeling or slicing vegetables, frying, baking or roasting meat, or following a recipe?

d. Has there been any change in the way you prepare meals (for example, the type of meals you prepare, the time you spend preparing meals, how often you prepare meals) because of your illnesses, injuries, or conditions? YES NO

If "NO," go to question **15.**

If "YES," pleases **DESCRIBE** the changes. _____

_____

_____

_____

15. **HOUSE AND YARD WORK**

a. Do you do any house or yard work (for example, wash dishes, laundry, ironing, dusting, vacuuming, household repairs, home improvement projects, mow a lawn, gardening)?

YES NO

If "NO," please **EXPLAIN** why not. _____

_____

_____

If "YES," **LIST** the household or yard work that you do._____

_____

_____

_____

b. Has there been a change in the **way** you do the house or yard work listed in **15.a.** or in the **time** it takes you to do the work because of your illnesses, injuries, or conditions? YES NO

If "NO," go to **c.**

If "YES," please **LIST** any house or yard work you do in which there has been a change and **DESCRIBE** the change. Please be **SPECIFIC**. _____

_____

_____

_____

_____

c. Do you need help, reminders, or encouragement to do any of the house or yard work you do?

YES NO

If "NO," go to question **16.**

If "YES," **LIST** each activity for which you need help, reminders, or encouragement, **DESCRIBE** why you need the help, reminders, or encouragement, and **LIST** who provides the help, reminders, or encouragement._____

_____

_____

_____

_____

16. **SHOPPING**

a. Do you do any shopping for yourself or others? YES NO

If "NO," go to **d.**

If "YES," do you shop: (Check "YES" for **ALL t**hat apply)

1. In the stores? YES NO **3.** By mail (catalogue)? YES NO

2. By phone? YES NO **4.** By computer? YES NO

b. Do you shop for:

1. Groceries? YES NO

If "NO," go to **2.**

If "YES," **HOW OFTEN** do you shop for groceries? _____

_____

_____

2. Clothing (for yourself or others)? YES NO

If "NO," go to **3.**

If "YES," **HOW OFTEN** do you shop for clothing? _____

_____

_____

_____

3. Other shopping? YES NO

If "NO," go to **d.**

IF "YES," **DESCRIBE** what you shop for and **HOW OFTEN** you do this type of shopping?_____

_____

_____

_____

c. Has there been any change in the way you shop (for example, you now shop more by phone), or in your shopping habits (for example, you shop less often) because of your illnesses, injuries, or conditions? YES NO.

If "NO," go to question **17.**

If "YES," please **DESCRIBE** the change Please be **SPECIFIC**. _____

_____

_____

_____

_____

d. If you **do not** shop for yourself or others, is this a change? YES NO

If "NO," go to question 17.

If "YES," please **DESCRIBE** the change. Please be **SPECIFIC**. _____

_____

_____

_____

17. SOCIAL ACTIVITIES

a. Do you do things with other people (in person, on the phone, on the computer, etc.)?

YES NO

If "NO," go to **c.**

If "YES," please **DESCRIBE** the kinds of things you do with other people.

_____

_____

_____

b. How often do you do each of the things you described in **a.**?

_____

_____

_____

c. Are there things you do outside your home or places you go on a regular basis (religious services, community center, sports events, social groups, visit with family or friends, etc.)?

YES NO.

If "NO," go to **e.**

If "YES," for each thing you do or place you go, **TELL** how often you do the activity or go to the place and what you do there (for example, weekly Sunday morning church service, monthly community meeting-treasurer, watch weekly little league games during season).

_____

_____

d. Has there been any change in your social activities because of your illnesses, injuries, or conditions? YES NO

If "YES," **DESCRIBE** the change. Please be **SPECIFIC.**

_____

_____

_____

_____

e. Do you get along with others (family, friends, neighbors, etc.)?

YES NO

If "YES," go to **f.**

If "NO" please **EXPLAIN** why not. Please be **SPECIFIC**.

_____

_____

_____

_____

f. Do you get along with authority figures (for example, police, a boss, landlord, or teacher)?

YES NO

If "YES," go to **g.**

If "NO," please **EXPLAIN** in what way you do not get along with authority figures._____

_____

_____

_____

_____

g. Have you ever quit, been fired, or been laid off from a job because of your injuries, illnesses, or conditions? YES NO

If "NO," go to question **18.**

If "YES," please **EXPLAIN** what happened._____

_____

_____

_____

18. **HOBBIES AND INTERESTS**

a. Do you have any hobbies or interests (for example, reading, watching TV, sewing, playing, or watching sports, bingo, playing cards, fishing, hunting, camping, gardening, or computer)?

YES NO NEVER HAD ANY HOBBIES OR INTERESTS

If you checked "NO" or "NEVER HAD ANY HOBBIES OR INTERESTS," go to **Section D.**

If "YES," please **LIST** each hobby or interest and **HOW OFTEN** you do it._____

_____

_____

_____

b. Has there been any change in your ability to do any of the hobbies or interests you listed **or** the time you spend on them because of your illnesses, injuries, or conditions?

YES NO

If "NO," go to **Section D.**

If "YES," please **DESCRIBE** the change. Pleases be **SPECIFIC.**

_____

_____

_____

SECTION D – OTHER INFORMATION

19. Answering this question is optional. Is there anyone you haven't already told us about (relative, friend, neighbor, former coworker, or boss) that we may contact (other than your doctors or the person you named on your disability report) who knows about your illnesses, injuries, or conditions?

Name _____ Relationship _____

Address _____

(Number, Street, Apartment. Number (if any), P.O. Box or Rural Route

_____

City State Zip Code Daytime Phone Number_____

If you completed this form for yourself, go to Section E.

If you completed this form for the person applying for or receiving disability benefits, please complete the information in question 20. When you are done with questions **20.a**. and **20.b**, go to **Section E**.

20. a. What is your relationship to the disabled person (for example, spouse, neighbor, friend)?

_____

_____

_____

b. Please **EXPLAIN** why you are completing this form for the person applying for or receiving disability benefits.

SECTION E - -REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you don't have anything to add), **be sure to complete the information requested on the bottom of page 14.**

Name of person completing this form (Please Print) Date (month, day, year)

Address (Number and Street) email address (optional)

City State Zip Code

Your daytime telephone number (Area code and number)