

# 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 disability decision on your disability claim. 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 abilities.

- Print or type.
- **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 explain an answer if the question asks for an explanation, or if you think you need to explain an answer.
- If more space is needed to answer any questions, use the "REMARKS" section on Page 8, and show the number of the question being answered.

**REMEMBER TO GIVE US THE NAME AND ADDRESS OF THE PERSON  
COMPLETING THIS FORM ON PAGE 8**

# Privacy Act and Paperwork Reduction Act Statements

**Collection and Use of Personal Information** - Sections 205(a), 1631(d)(1) and 1631(e)(1) of the Social Security Act (42 U.S.C. § 404), as amended, authorize us to collect this information. We will use the information you provide to assist us in making a decision on your claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate decision on your claim.

We rarely use the information you supply for any purpose other than the reason stated above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an 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 Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of 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 provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in our System of Records Notices entitled, Master Files of Social Security Number (SSN) Holders and SSN Applications System, 60-0058; Claims Folders Systems, 60-0089; and Master Beneficiary Record, 60-0090. These notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at any local Social Security office.

**Paperwork Reduction Act Statement** - 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 about 61 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING 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 (TTY 1-800-325-0778).** 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.**

**PLEASE REMOVE THIS SHEET BEFORE RETURNING  
THE COMPLETED FORM.**

**FUNCTION REPORT - ADULT**

*How your illnesses, injuries, or conditions limit your activities*

**For SSA Use Only**  
Do not write in this box.

Related SSN \_\_\_\_\_

Number Holder \_\_\_\_\_

**SECTION A - GENERAL INFORMATION**

1. **NAME OF DISABLED PERSON** *(First, Middle Initial, Last)*

2. **SOCIAL SECURITY NUMBER**

[Redacted area]

3. **YOUR DAYTIME TELEPHONE NUMBER** *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

\_\_\_\_\_  Your Number     Message Number     None  
*Area Code      Phone Number*

4. a. Where do you live? *(Check one.)*

- House             Apartment             Boarding House             Nursing Home
- Shelter             Group Home             Other *(What?)* \_\_\_\_\_

b. With whom do you live? *(Check one.)*

- Alone             With Family             With Friends
- Other *(Describe relationship.)* \_\_\_\_\_

**SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS**

5. How do your illnesses, injuries, or conditions limit your ability to work?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**SECTION C - INFORMATION ABOUT DAILY ACTIVITIES**

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6. Describe what you do from the time you wake up until going to bed.

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7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other?  Yes  No

If "YES," for whom do you care, and what do you do for them? \_\_\_\_\_

8. Do you take care of pets or other animals?  Yes  No

If "YES," what do you do for them? \_\_\_\_\_

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9. Does anyone help you care for other people or animals?  Yes  No

If "YES," who helps, and what do they do to help? \_\_\_\_\_

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10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

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11. Do the illnesses, injuries, or conditions affect your sleep?  Yes  No

If "YES," how? \_\_\_\_\_

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12. **PERSONAL CARE** (Check here  if **NO PROBLEM** with personal care.)

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

Dress \_\_\_\_\_

Bathe \_\_\_\_\_

Care for hair \_\_\_\_\_

Shave \_\_\_\_\_

Feed self \_\_\_\_\_

Use the toilet \_\_\_\_\_

Other \_\_\_\_\_

b. Do you need any special reminders to take care of personal needs and grooming?  Yes  No  
If "YES," what type of help or reminders are needed? \_\_\_\_\_  
\_\_\_\_\_

c. Do you need help or reminders taking medicine?  Yes  No  
If "YES," what kind of help do you need? \_\_\_\_\_  
\_\_\_\_\_

**13. MEALS**

a. Do you prepare your own meals?  Yes  No  
If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.) \_\_\_\_\_  
\_\_\_\_\_

How often do you prepare food or meals? (For example, daily, weekly, monthly.)  
\_\_\_\_\_

How long does it take you? \_\_\_\_\_

Any changes in cooking habits since the illness, injuries, or conditions began?  
\_\_\_\_\_

b. If "No," explain why you cannot or do not prepare meals. \_\_\_\_\_  
\_\_\_\_\_

**14. HOUSE AND YARD WORK**

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) \_\_\_\_\_  
\_\_\_\_\_

b. How much time does it take you, and how often do you do each of these things?  
\_\_\_\_\_

c. Do you need help or encouragement doing these things?  Yes  No  
If "YES," what help is needed? \_\_\_\_\_  
\_\_\_\_\_

d. If you don't do house or yard work, explain why not. \_\_\_\_\_

\_\_\_\_\_

**15. GETTING AROUND**

a. How often do you go outside? \_\_\_\_\_

If you don't go out at all, explain why not. \_\_\_\_\_

\_\_\_\_\_

b. When going out, how do you travel? (*Check all that apply.*)

Walk       Drive a car       Ride in a car       Ride a bicycle

Use public transportation       Other (*Explain*) \_\_\_\_\_

c. When going out, can you go out alone?  Yes       No

If "NO," explain why you can't go out alone. \_\_\_\_\_

\_\_\_\_\_

d. Do you drive?  Yes       No

If you don't drive, explain why not. \_\_\_\_\_

\_\_\_\_\_

**16. SHOPPING**

a. If you do any shopping, do you shop: (*Check all that apply.*)

In stores       By phone       By mail       By computer

b. Describe what you shop for. \_\_\_\_\_

\_\_\_\_\_

c. How often do you shop and how long does it take? \_\_\_\_\_

\_\_\_\_\_

**17. MONEY**

a. Are you able to:

Pay bills       Yes       No      Handle a savings account       Yes       No

Count change       Yes       No      Use a checkbook/money orders       Yes       No

Explain all "NO" answers. \_\_\_\_\_

\_\_\_\_\_

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began?  Yes  No  
If "YES," explain how the ability to handle money has changed. \_\_\_\_\_  
\_\_\_\_\_

**18. HOBBIES AND INTERESTS**

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

\_\_\_\_\_  
\_\_\_\_\_

b. How often and how well do you do these things? \_\_\_\_\_  
\_\_\_\_\_

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

\_\_\_\_\_  
\_\_\_\_\_

**19. SOCIAL ACTIVITIES**

a. Do you spend time with others? (*In person, on the phone, on the computer, etc.*)  Yes  No

If "YES," describe the kinds of things you do with others. \_\_\_\_\_  
\_\_\_\_\_

How often do you do these things? \_\_\_\_\_

b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.) \_\_\_\_\_  
\_\_\_\_\_

Do you need to be reminded to go places?  Yes  No

How often do you go and how much do you take part? \_\_\_\_\_  
\_\_\_\_\_

Do you need someone to accompany you?  Yes  No

c. Do you have any problems getting along with family, friends, neighbors, or others?  Yes  No

If "YES," explain. \_\_\_\_\_  
\_\_\_\_\_

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.  
\_\_\_\_\_  
\_\_\_\_\_

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### SECTION D - INFORMATION ABOUT ABILITIES

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20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

- |                                    |                                   |                                           |                                                    |
|------------------------------------|-----------------------------------|-------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Lifting   | <input type="checkbox"/> Walking  | <input type="checkbox"/> Stair Climbing   | <input type="checkbox"/> Understanding             |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Seeing           | <input type="checkbox"/> Following Instructions    |
| <input type="checkbox"/> Bending   | <input type="checkbox"/> Kneeling | <input type="checkbox"/> Memory           | <input type="checkbox"/> Using Hands               |
| <input type="checkbox"/> Standing  | <input type="checkbox"/> Talking  | <input type="checkbox"/> Completing Tasks | <input type="checkbox"/> Getting Along With Others |
| <input type="checkbox"/> Reaching  | <input type="checkbox"/> Hearing  | <input type="checkbox"/> Concentration    |                                                    |

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

b. Are you:  Right Handed?  Left Handed?

c. How far can you walk before needing to stop and rest? \_\_\_\_\_  
If you have to rest, how long before you can resume walking? \_\_\_\_\_

d. For how long can you pay attention? \_\_\_\_\_

e. Do you finish what you start? (For example, a conversation, chores, reading, watching a movie.)  Yes  No

f. How well do you follow written instructions? (For example, a recipe.) \_\_\_\_\_  
\_\_\_\_\_

g. How well do you follow spoken instructions? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.) \_\_\_\_\_

\_\_\_\_\_

i. Have you ever been fired or laid off from a job because of problems getting along with other people?  Yes  No

If "YES," please explain. \_\_\_\_\_

\_\_\_\_\_

If "YES," please give name of employer. \_\_\_\_\_

j. How well do you handle stress? \_\_\_\_\_

\_\_\_\_\_

k. How well do you handle changes in routine? \_\_\_\_\_

\_\_\_\_\_

l. Have you noticed any unusual behavior or fears?  Yes  No

If "YES," please explain. \_\_\_\_\_

\_\_\_\_\_

21. Do you use any of the following? (Check all that apply.)

- |                                          |                                          |                                                 |
|------------------------------------------|------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Crutches        | <input type="checkbox"/> Cane            | <input type="checkbox"/> Hearing Aid            |
| <input type="checkbox"/> Walker          | <input type="checkbox"/> Brace/Splint    | <input type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair      | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box   |
| <input type="checkbox"/> Other (Explain) | _____                                    |                                                 |

Which of these were prescribed by a doctor? \_\_\_\_\_

\_\_\_\_\_

When was it prescribed? \_\_\_\_\_

\_\_\_\_\_

When do you need to use these aids? \_\_\_\_\_

\_\_\_\_\_

22. Do you currently take any medicines for your illnesses, injuries, or conditions?  Yes  No

If "YES, "do any of your medicines cause side effects?  Yes  No

If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE

**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 didn't have anything to add), be sure to complete the fields at the bottom of this page.

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Name of person completing this form (Please print)		Date ( <i>month, day, year</i> )	
Address (Number and Street)		Email address (optional)	
City	State	ZIP Code	