

INDIVIDUAL PRODUCTIVITY ASSESSMENT

HOUSEHOLD ACTIVITY CAPACITY

Name: _____

Date: _____

Routine/General Housekeeping (Daily and routine housecleaning, meal preparation and clean-up, bed linens, clothes maintenance – laundry, ironing, clothes storage)

Prior to Disability _____ **Hours/Week** _____

After Disability:

_____ **Replacement:** _____

Grocery Shopping (Travel to store, selecting items, transporting to home, carrying and placing groceries in appropriate place)

Before Disability _____ **Hours/Week** _____

After Disability: _____

_____ **Replacement:** _____

General Shopping and Errands

Before Disability _____ **Hours/Week** _____

After Disability _____
_____ **Replacement:** _____

Heavy Housecleaning (Bathrooms, windows, fans, refrigerator/stove, carpet/deck, floors-hardwood/tile, carpets, baseboards, blinds, glass doors, air conditioning vents)

Before Disability _____ **Hours/Week** _____

After Disability _____

_____ **Replacement:** _____

Yard/Garden Activity (Lawn-mow/edge/fertilize, flowers-plant/maintain/fertilize, prune shrubbery/trees, water, rake/clean yard, clean driveway)

Before Disability _____ **Hours/Week** _____

After Disability: _____

_____ **Replacement:** _____

Home Maintenance (Paint, minor repairs, clean roof/gutters, air conditioning/heating filters, clean skylights, change light bulbs, etc.)

Before Disability _____ **Hours/Month** _____

After Disability _____

_____ **Replacement:** _____

Auto Maintenance (Vacuum, wash, wax)

Before Disability _____ **Hours/Month** _____

After Disability _____
_____ **Replacement:** _____

Counselor _____