REGIONAL THERAPY CENTER
A SERVICE OF SARATOGA HOSPITAL

211 Church Street • Saratoga Springs, NY 12866

SARA™
SELF-ASSESSMENT QUESTIONNAIRE

Last Name	First Name	MI
Account Number	Inpatient Room Number	
HO Number	DOB	
Physician		

☐ Initial Visit ☐ Final Visit ☐ Follow-up: _____ Months

Complete this questionnaire to help us to understand how you are currently performing and managing your daily activities and what we need to focus on to help you the most. ***Also, please tell us what you expect from the care you are here to receive:***

I expect: ____

Date	Patient's or Representative's Signature	If Completed by a Representative, Your Relationship to the Patient

INSTRUCTIONS

Using the scale below, please rate your ability to perform and manage daily activities.

RATING	LEVEL OF FUNCTION
DD	Normally don't do: **Never have to, want to and/or plan to do.**
0	No problem at all: **Can do when and how you want, and without pain.**
1	Minor problem: **Can do without help, but with pain or minor annoyance.**
2	Moderate problem: **Need some help, or can't do the way you'd like to do it.**
3	Major problem: **Need a lot of help, very hard to complete, or cannot do safely.**
4	Can't do at all: **Would like to do again.**

Please rate your ability to perform each task ***even if*** the difficulty you are experiencing performing the task ***is not related*** to the condition for which you will be or have been receiving care.

SELF CARE	☐ No Problems, Skip to Next Box
Feeding yourself	0 1 2 3 4
Dressing	0 1 2 3 4
Grooming	0 1 2 3 4
Bathing/showering	0 1 2 3 4
Toileting	0 1 2 3 4

EATING	☐ No Problems, Skip to Next Box
Swallowing	0 1 2 3 4
Chewing	0 1 2 3 4
Eating or Drinking without coughing or choking	0 1 2 3 4
Satisfying my appetite	0 1 2 3 4

MANAGING HOUSEHOLD	
Cooking	DD 0 1 2 3 4
Washing dishes	DD 0 1 2 3 4
Doing Laundry	DD 0 1 2 3 4
Housekeeping	DD 0 1 2 3 4
Shopping	DD 0 1 2 3 4
Yard work	DD 0 1 2 3 4

Please Continue With Items on the Back

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Ratings: **DD = Normally Don't Do** **0 = No Problem At All** **1 = Minor Problem**
2 = Moderate Problem **3 = Major Problem** **4 = Can't Do At All**

MAINTAINING POSITIONS

Lying down/Sleeping	0	1	2	3	4
Prolonged Sitting	0	1	2	3	4
Prolonged Standing	0	1	2	3	4
Squatting	0	1	2	3	4
Kneeling	0	1	2	3	4

MOVEMENT

Moving your arms and legs	0	1	2	3	4
Moving your neck and back	0	1	2	3	4
Getting into desired position (out of bed or a chair, etc)	0	1	2	3	4
Walking	0	1	2	3	4
Climbing stairs or a step up	0	1	2	3	4

PHYSICAL DEMANDS

Driving or traveling	0	1	2	3	4
Lifting	0	1	2	3	4
Bending over	0	1	2	3	4
Carrying	0	1	2	3	4
Reaching	0	1	2	3	4
Twisting your back	0	1	2	3	4
Pushing/pulling	0	1	2	3	4

MANIPULATIVE SKILLS

Gripping objects	0	1	2	3	4
Picking up small objects	0	1	2	3	4
Writing	0	1	2	3	4
Using push buttons or a keyboard	0	1	2	3	4
Turning a knob	0	1	2	3	4
Using arm or hand repetitively	0	1	2	3	4

RECREATION & LEISURE

Sports (baseball, running, golf, bowling, etc.)	DD	0	1	2	3	4
Social gatherings, going out to eat, etc.	DD	0	1	2	3	4
Art (painting, sculpturing, drawing, etc.)	DD	0	1	2	3	4
Performing Arts (playing an instrument, singing, dancing)	DD	0	1	2	3	4
Hobbies (knitting, sewing, playing cards, woodwork, gardening, volunteer,etc.)	DD	0	1	2	3	4

EMPLOYMENT (☐ Or Check for SCHOOL)

☐ Will Never Do Again, Skip To Next Box

Regular scheduled hours	0	1	2	3	4
Performing normal tasks/duties	0	1	2	3	4

CARING FOR OTHERS

☐ Don't Normally Do, Skip To Next Box

Providing needed hours of care	0	1	2	3	4
Doing/completing needed tasks	0	1	2	3	4

PAIN and/or SYMPTOM LEVEL: Circle the number that equals your pain &/or symptom level.

None = 0 1 2 3 4 5 6 7 8 9 10 = **Worst** Possible

COMPLETE THIS BOX: ONLY if this is your last or only visit, or if this is a follow-up survey

Did things turn out the way you expected?

0	**1**	**2**	**3**	**4**
Did not meet my expectation		Met my expectation		Exceeded my expectation

Your Comments:

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Total Score ☐

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