Form C: to be completed by the patient

PHYSICAL SELF MAINTENANCE SCALE (PSMS)

Circle the number to the right of the statement that best describes you in regards to the following activities.

1. Do you eat

a.	without any help,	3
b.	with some help (cutting food, identifying for blind, etc.), or	2
c.	does someone feed you?	1

2. Do you dress and undress yourself

a.	without any help (pick out clothes, dress and undress yourself),	3
b.	with some help (dressing or undressing), or	2
c.	does someone dress and undress you?	1

3. Do you take care of your own appearance, things like combing your hair, shaving (for men)

a.	without help,	3
b.	with some help, or	2
c.	does someone do these things for your	1

4. Do you get around your house/apartment/room

a.	without help of any kind (except for cane),	3
b.	with some help (from a person, walker, crutches, chair), or	2
c.	don’t get around your home at all unless someone moves you	1

5. Do you get in and out of bed

a.	without help	3
b.	only with some help from a person or device, or	2
c.	don’t get in and out of bed unless someone lifts you	1

6. Do you bathe- that is, take a bath, shower, or sponge bath

a.	without any help,	3
b.	with some help from a person or device, or	2
c.	Only when someone bathes you (lifts you in and out, or bathes)	1

7. Do you have trouble getting to the bathroom on time?

a.	yes	1
b.	no	2

8. About how often do you wet/soil yourself during the day or night

a.	Never	4
b.	Less than once a week	3
c.	Once or twice a week	2
d.	Three times or more a week	1