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How to Start Using the Allen Diagnostic Module

A Guide to Introducing Allen's Theories Into Your Practice

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The cognitive levels measure a person's ability to function. A large number of resources are available to make that measurement fair, objective and relevant to an individual's lifestyle. Universal human abilities to function are emphasized to promote cross-cultural use of the cognitive levels with mental disorders, brain damage and physical disabilities. Criteria for establishing task equivalence are used to establish the functional complexity of any activity that an individual wants to do. The same criteria for task equivalence are used to analyze the severity of underlying impairments and identify remaining abilities. Successful performance and functional outcomes occur when the activity demands match the individual's remaining abilities.

The meaning of change in ability to function is important to individuals, their loved ones, their social support systems and healthcare planners. The cognitive levels go beyond services delivered to individuals to consider other people and environments influenced by disability. Each cognitive level is associated with lists of environmental modifications for realistic ability to use adaptive equipment and safety devices. Specific types of caregiver assistance are also associated with the cognitive levels. Occupational therapists use the cognitive levels to make recommendations and issue warnings to other caregivers and healthcare planners. The purpose of the recommendations and warnings is to encourage the safe use of the individual's remaining abilities. The occupational therapist's role is to design and test activity environments that use remaining abilities and to instruct others in maintaining those environments.

The cognitive levels suggest a new role and more responsibilities for occupational therapists. When change in ability to function is expected, continuously evaluate the person's ability to process new information to measure change. Repetitive drilling in any single activity is apt to give a false measure. Ability to function is a global measure, and an improvement in an isolated activity is apt to mislead one into thinking that an overall improvement has occurred. Repetitive drilling is useful when no further change in overall ability to function is expected. Drilling is used to teach safe activity performance in the specific setting, without expected generalization to other settings or activities. The therapist designs the drilling procedure and teaches the techniques to other long-term caregivers. When no residual disabilities are expected, the therapist objectively measures the return of pre-morbid ability to function. When new residual disabilities are expected, the therapist measures the severity of the disability and explains the necessary changes in lifestyle to everyone involved with the individual's care. The new responsibilities for the occupational therapist go beyond direct patient care and include what happens to the patient after discharge from occupational therapy.

For those who choose to assume the additional responsibilities, this booklet is designed to help you use the resources available to you. Before you begin, allow at least a year to feel confident after many hours of study. Put up a sign that reads: "If you are not confused or anxious around here, you are not trying hard enough." Learning to understand the various ways that the human brain works is difficult because the brain is so wonderfully complex. What you are trying to learn is difficult because the brain is so complicated. Do not assume that you are stupid, and give yourself credit for tackling one of the most difficult subjects of all.

The quickest and easiest thing to learn is how to administer the screening tool, the Allen Cognitive Level (ACLS) test. A larger version, the LACLS, is available. You should get both to learn the pros and cons of each at this time. The ACLS is the preferred method. The LACLS seems to correlate with the ACLS and is best for the elderly and the visually impaired. Both use 3 leather lacing stitches to assess ability to process new information. Many therapists administer the test after an initial interview, when some rapport with the patient has been established. The ACLS provides a quick estimate of how well a person is functioning in levels 3 through 5. The lower levels (1 and 2) are assessed by observing behavioral responses to stimuli. Level 6 is the universal potential capacity to function, requiring planning and premeditated actions and is not assessed by the screening tool. Occupational therapists are usually asked about patients who are functioning in the middle of the scale, which is covered by the ACLS. The ACLS score will probably be accurate about 90% to 95% of the time. Visual impairments and previous leather lacing experience are the most common explanations for errors. To assess one-handed individuals, therapists may hold the leather or place the leather

in a swivel embroidery hoop (Allen, 1985; Allen, Earhart and Blue, 1992).

The Allen Diagnostic Module (ADM) is designed to verify the ACLS score. Thirty-five craft projects have been standardized to control the new information presented to individuals who tend to deny any functional limitations. The projects are selected to match the ACLS score and must have meaning to the individual. Making a project is the reason the individual is functioning at his or her best ability. The activity itself must be valued by the individual. Individuals who do not value craft projects exist, of course, and other activities that are valued will have to be analyzed by therapists. Crafts were selected because they can be standardized to present new information that is meaningful to the disabled most of the time. The ADM contains extensive rating criteria for the modes of performance that feature a decimal system added to the original 6 cognitive levels. The modes are sensitive to small degrees of change in ability to function that can be objectively monitored when change is expected. The rating system allows for fluctuation in ability to function, and a range of scores can be reported. Ratings can be done while observing individuals or groups of people, with recommendations for group size with each activity. Generic rating sheets and definitions identify common discriminating factors, with more detailed discriminators given for each project. The probes identified for each mode and activity are a means of evaluating an expected improvement in ability to function. The tables help you select projects according to ACLS score, length of time to complete and practice situation (Earhart, Allen and Blue, 1993 Revised 2003). Refer to the rating sheets and tables at the back of this booklet for a sampling of what is available in the ADM.

The Routine Task Inventory (RTI) helps you interpret the ACLS and ADM scores. The original RTI included 6 cognitive levels and was not sensitive to small degrees of change in ability to function (Allen, 1985). The modes (decimal points) were added to the analysis of the activities of daily living in the 1992 publication (Allen, Earhart and Blue). The analysis of activities done in the RTI is for a global cognitive deficit without focal lesions, hearing or vision problems, or physical disabilities. Additional impairments are factored in after a general understanding of ability to function is identified. The RTI can be used to set short- and long-term goals, make discharge recommendations, consult with long-term caregivers and advocate for healthcare reform.

Treatments and compensations for physical disabilities are analyzed according to cognitive complexity in separate chapters by Blue (Allen, Earhart and Blue, 1992). Blue suggests the minimum cognitive ability required to benefit from common treatment methods. Many common treatment failures can be avoided by making sure that the individual has the prerequisite ability to understand the treatment method. These chapters can be used to screen out treatment methods, adaptive equipment and safety devices that are not apt to be effective due to a cognitive disability.

These resources are designed to help you reorganize your practice of occupational therapy. The goal is to get realistic and relevant functional outcomes, but it may take you a while to get there. Start with the ACLS and ADM, which have been analyzed in great detail, and learn how to do a functional activity analysis from them. Use the RTI to check out the realities of your patients' lifestyles, before and after discharge. When you begin to understand ability to function, begin to educate the occupational therapist and other members of the treatment team. Some will understand fairly quickly and others may be very slow, resistive and threatened when they do not grasp the concept quickly. Many reject the concept without trying to understand. The critical factor is understanding the difference between ***will not*** and ***cannot***.

The cognitive levels account for changes in ability to function that are rooted in the biology of the brain. Brain pathology makes it impossible to process new information. The primary problem is lack of ability, not motivation. A person must have an ability to do an activity before they have a real choice about accepting or rejecting an activity. A change in ability to function occurs when brain pathology can be corrected through medications, reduced toxicity, natural healing, growth and development, or by progressive increase in pathology. We do not know if occupational therapy services or other environmental influences can cause improvements in brain pathology. We do know that occupational therapists can measure the functional changes and associated changes in brain pathology and explain how those changes

will influence lifestyle. The importance of an occupational therapist's knowledge is in predicting what a change in ability to function means to safe performance of the individual's ordinary activities, as well as the individual's need for assistance. The measurement of ability to function must be made while the individual is processing new information. Functioning occurs in an ever-changing environment that constantly provides new information. Predictions about safety and need for assistance must be based on the person's ability to process the unexpected, but inevitable, changes in the environment. When a person is unaware of new information, another person may need to be present to process the information and remove the dangerous object or establish safety precautions. When caregivers think that the problem is motivation, they tend to blame the patient for the problem and do not institute or follow the necessary safety procedures. The distinction between cannot and will not is subtle, but crucial to protecting the cognitively disabled person's dignity and safety (Allen and Robinson, 1993).

Educating others about the difference between cannot and will not is a major part of the occupational therapist's new responsibilities. Two short articles are available to help you (Allen and Allen, 1987; Allen, 1991). Collaborate with members of the treatment team in consulting with families and other long-term caregivers. Choose your educational battles wisely, according to who listens and where you can have the greatest impact. Let the other battles go. Occupational therapists who have incorporated these principles into their practice will find themselves in an improved position to advocate for realistic and meaningful functional outcomes for their clients.

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Earhart, C.A., Allen, C.K. and Blue, T. **Allen Diagnostic Module**. S&S® Worldwide, Colchester, CT, USA, 1993. Revised 2003.

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Consequences of Disabilities
Claudia Kay Allen, MA, OTR, FAOTA

Disabilities are the consequences of medical problems that can limit a person's physical and cognitive abilities. Adapt to physical disabilities by providing physical assistance, adaptive equipment and removing architectural barriers. The functional outcome of a physical disability may be finding a niche in the mainstream of community life. Cognitive disabilities may be adapted to by providing cognitive assistance that compensates for the person's inability to process new information. The functional outcome for a cognitive disability may be protecting the person from danger to self or others.

Disability*	Compensation	Outcome
Physical Assistance No Cognitive Assistance Level 6	Adaptive Equipment Remove Barriers	Worker Community Activities Independent Living Family Life Retiree
Standby Cognitive Assistance Level 5	Planner Advisor Supervisor	Worker Community Activities Independent Living
Minimum Cognitive Assistance Level 4	Help at Home	Self-care
Moderate Cognitive Assistance Level 3	Help with Self-care	Repetitive Actions
Maximum Cognitive Assistance Level 2	Prevent Getting Lost	Walk, Exercise
Total Cognitive Assistance Level 1	Sensory Stimulation	Respond to Cues

*Cognitive Assistance codes are from Medicare; the levels are the Allen Cognitive Levels.

When both physical and cognitive disabilities are present, the cognitive disability limits the outcome. A person functioning at level 4 will need help at home and may not be able to learn to use some adaptive equipment such as sock aids and button hooks. Treatment aims at setting up a home program that makes the most meaningful use of all remaining abilities.

ADM Analysis Tables 1 & 2

The ADM Analysis Tables list the 35 craft activities in the Allen Diagnostic Module. The activities are designed to assess a range of cognitive levels. The Tables indicate the crafts on the left side of the table. The range of cognitive levels or modes assessed by each activity is indicated by the dark bar across the table, spanning the appropriate cognitive mode columns.

It is not necessary to purchase all 35 ADM activities. Therapists should select those that assess the range of cognitive levels seen in their practice situation. To further assist selection, the activities have been grouped in terms of suitability for use in several common practice conditions: use at bedside, use with persons with poor vision, use with one-handed persons, use in home health (portability).

The craft activities have been designed to meet a variety of time requirements from quick (around 15 minutes) to longer (several hours). Some projects are particularly suitable for group assessments, having easy set-ups with minimal requirements for tools.

Analysis Table 1

Activity	3.0	3.2	3.4	3.6	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.2	5.4	5.6	5.8
Sticker Cards	■	■	■	■	■	■	■	■	■						
Mug	■	■	■	■	■	■	■	■	■						
Canvas Place Mat	■	■	■	■	■	■	■	■	■						
Visor	■	■	■	■	■	■	■	■	■						
Stamped Cards	■	■	■	■	■	■	■	■	■						
Frog Note Holder	■	■	■	■	■	■	■	■	■						
Whale Note Holder	■	■	■	■	■	■	■	■	■						
Felt Turtle	■	■	■	■	■	■	■	■	■						
Foam Sun Hanger	■	■	■	■	■	■	■	■	■	■					
Bargello Bookmark	■	■	■	■	■	■	■	■	■	■					
Bead Kit I	■	■	■	■	■	■	■	■	■	■					
Recessed Tile Box	■	■	■	■	■	■	■	■	■	■					
Tile Trivet	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Button Bookmark				■	■	■	■	■	■						
Button Frame				■	■	■	■	■	■						
Fabric Notebook						■	■	■	■	■					
Ribbon Card						■	■	■	■	■	■				
Storage Box						■	■	■	■	■	■				

Analysis Table 2

Activity	3.0	3.2	3.4	3.6	3.8	4.0	4.2	4.4	4.6	4.8	5.0	5.2	5.4	5.6	5.8
Indian Key Fob															
Hug-A-Bear															
Bear Clothes I (4)															
Boy & Girl Rag Dolls															
Turtle Key Ring															
Jute Purse															
Jute Tote Bag															
Bead Kit II															
Fabric Covered Box															
Heart Key Ring															
Bear Clothes II (5)															
Secretary Box															
Stenciled Card															
Initial Key Ring															
Flag Magnet															
Safety Coaster															
Stamped Stationery															
Needlepoint Coaster															

Practice Situation

BEDSIDE
Mug
Place Mat
Sticker Cards
Bargello Bookmark
Indian Key Fob
Ribbon Cards
Visor
Storage Box
Sun Hanger
Felt Turtle
Button Bookmark
Button Frame
Bead Projects
Fabric-Covered Notebook
Fabric-Covered Box
Stamped Card
Stamped Stationery
Needlepoint Projects
Boy & Girl Rag Dolls
Jute Purse/Tote
Hug-A-Bear
Bear Clothes

POOR VISION
Mug
Place Mat
Bargello Bookmark
Indian Key Fob
Ribbon Cards
Visor
Storage Box
Sun Hanger
Fabric-Covered Notebook

ONE HAND
Mug
Place Mat
Sticker Cards
Bargello Bookmark*
Needlepoint Projects*
Visor
Storage Box
Sun Hanger
Felt Turtle*
Stenciled Card
Stamped Card
Stamped Stationery

PORTABLE (HOME HEALTH)
Mug
Place Mat
Sticker Cards
Bargello Bookmark
Indian Key Fob
Ribbon Cards
Visor
Storage Box
Sun Hanger
Felt Turtle
Button Bookmark
Button Frame
Bead Projects
Fabric-Covered Notebook
Fabric-Covered Box
Hug-A-Bear
Bear Clothes

Length of Assessment

Listed in Order of Complexity – Lowest Mode to Highest Mode

15 to 30 MINUTES
Place Mat
Sticker Cards
Bargello Bookmark
Sun Hanger
Visor
Fabric-Covered Box
Fabric-Covered Notebook
Caribbean Beads I
Felt Turtle
Ribbon Cards
Beaded Turtle Key Ring
Stamped Cards
Indian Key Fob (4.6+)
Caribbean Beads II
Stenciled Cards

30 to 60 MINUTES
Mug
Whale Note Holder
Recessed Box
Tile Trivet
Frog Note Holder
Foam Button Bookmark
Foam Button Frame
Storage Box
Indian Key Fob (4.0-4.4)
Bear Clothes (4)
Bear Clothes (5) (Hats only)
Stenciled Card
Stamped Stationery

60+ MINUTES
Bear Clothes (5) (Vests)
Boy & Girl Rag Dolls
Jute Tote
Jute Purse
Needlepoint Heart Key Ring
Needlepoint Initial Key Ring
Needlepoint Flag Magnet
Needlepoint Coaster
Tile Trivet with Grout
Secretary Box

Easy Group Setup
Mug
Place Mat
Visor
Sun Hanger
Ribbon Cards

Individual (Several Days)
Boy & Girl Rag Dolls
Jute Tote and Purse
Needlepoint Projects
Secretary Box

Special Assessment
Frog Note Holder (Dementia)

*Needs to be held by therapist or adaptive device.

Common Questions

1. How can the ADM be used for treatment?

The ADM provides an opportunity for people to use their remaining abilities. The materials, directions and prompts are designed to use as many abilities as possible. Decades of clinical experience have gone into figuring out what people with mental disorders can still do successfully. Therapists can provide a "just-right challenge" with great precision and most patients will enjoy doing these projects... even some patients with an initial aversion to crafts.

2. What should I buy for the basic setup?

The basic components needed to understand Cognitive Level Theory and begin implementing the ideas include:

	Item #	Price	
a) Allen Cognitive Level Screen	HMK-HC98	$14.99	$9.99 each, 24 +.
b) Larger Allen Cognitive Level Screen	HMK-HC106	$24.99	$19.99 each, 24 +.
c) Allen Diagnostic Module Manual	HMK-CU26	$149.99	
d) Occupational Therapy Treatment Goals for the Physically and Cognitively Disabled	HMK-HC104	$112.99	

3. They enjoyed making a craft project. So what?

An OTR must explain what a change in ability to function or a residual cognitive disability means to the individual and the family. The difference between ***will not*** and ***cannot*** is very confusing to everyone. When a person enjoys making a craft project, a distinction between will and can is possible.

4. What happens with patients who do not enjoy manual crafts?

The therapist has to come up with another activity. An activity that the individual does enjoy must be identified and analyzed.

5. How is the sequence of the cognitive levels organized?

The sequence of the cognitive levels organizes the individual's assets and limitations. A person evaluated as functioning at 4.4 is expected to be able to process new information required to do the activities described from 1.0 to 4.4. The limitations expected are described between 4.6 and 6.0. As much as possible, the sequence follows universal human development and decline in processing new information. The cognitive levels aim at being cross-cultural and applicable to all ages and any disease process that reduces brain functioning.

6. How do therapists generalize from observations of craft activity performance to what a person will do in the community?

The ADM craft activities control the new information presented by sensory cues and instruction methods. These same cues and instruction methods can be found in many aspects of human performance, making it possible for therapists to predict how people will function outside of the OT clinic and while doing other activities.

7. How does one account for what a person already knows how to do? What if the person has had a lot of experience in doing crafts?

Prior knowledge can invalidate a prediction of functional outcomes. People function better in doing activities that they have done a lot. Drilling effects can also invalidate predictions. The world is constantly changing and the human brain is designed to be flexible. Mental disorders reduce a person's ability to flexibly adapt to the changing world. To predict functional outcomes, therapists must present information that is new to the individual. Crafts are new to many people, but of course not to everyone. Be sure to ask patients if they have ever done anything like this before. If it is very familiar, you are going to have to find something else.

ADM Rating Criteria — Sample Page from General Rating Criteria. The general rating criteria were designed to make the most efficient use of the therapist's time. The rating criteria were developed by observing the performance of psychiatric patients. To be efficient and manageable in the clinic, the rating criteria needed to be as short as possible. An example page from the Rating Criteria is included in this manual.

3.4

Placing objects requires attention to a demonstration of placing objects in a row or taking them in or out of a container.

Sustaining actions requires attention to a repetitive action for at least one minute.

Talking to self requires attention to the use of concepts to direct movements.

Momentary awareness of effects requires a brief or inconsistent attention to the location of an action.

3.6

Placing objects at the edge requires attention to the perimeter or shape of the object (tiles placed around the frame but not in the middle of the recessed box).

Noting effects requires consistent attention to the intent of the action and making adjustments (move tile up or down, turn tile over) or commenting on the effects (messy).

Waiting for directions requires attention to a brief delay in actions and a readiness to imitate a new demonstration.

Noting gender requires attention to sexual characteristics and translating discriminations into speech (he/she).

3.8

Being done requires attention to whole space or a group of objects used in one step of the activity. What is done is the action (sanding) not the project (tile box).

Filling interior space requires attention to the middle of a flat surface (inside tiles of recessed box).

Continuing to act requires attention to a verbal cue for a different motor action (stirs stain when told).

Imitating three actions requires attention to a demonstration of a sequence of actions (stir, brush, wipe off stain).

Locating a room used daily requires attention to a sequence of movements used to reach a destination (OT clinic).

4.0

Sequencing steps requires attention to directing self through the steps required to complete a task (sanding, staining, tilting). The next step may be incorrect or patient may ask what the next step is. Awareness of the goal is consistent for duration of the activity and measures time by activity.

Recognizing an error when cued requires attention to comparing the sample to their own projects. The difference is noted but may not choose to correct the difference. Does not spontaneously refer to sample at the beginning of the activity.

Following a design requires attention to the idea of a pattern or a picture. The pattern may change or have idiosyncratic meanings not readily apparent to others.

Possessing a project requires attention to ownership: the person can keep the project or take it with him/her.

Distinguishing between us and them requires attention to the outward appearance of people (race, ethnicity) and sign of social rank (teacher, doctor). Engages in friendly contact rituals and asks for assistance.

ADM Rating Sheets — Sample Page. Rating sheets are provided in the form of one-page group evaluation sheets. These rating sheets were designed to help therapists conduct evaluations, and are to be used as notes. The therapist should be able to check off 50% to 75% of all behaviors observed during the group on the rating sheet. Rating sheets are especially useful in group settings and will help therapists develop their observational skills. The rating sheets section in the ADM includes three appendixes which help separate observations of "Environment and Time," "Social/Verbal Performance" and "Use of Sample and Instructions."

Date_____

ALLEN DIAGNOSTIC MODULE – RATING LEVEL 3.0-3.8

Name Check Behavior Observed						
3.0 Feels object						
Tunnel vision						
I.D. object						
Own name						
3.2 Moves object						
Customary Surface						
Stop/start						
Short phrases						
3.4 Places object						
Sustains						
Talks to self						
Momentary effect						
3.6 Places at edge						
Notes effects						
Waits for direction						
Gender						
Imitates 2 actions						
3.8 Done						
Fills interior						
Continue to act						
Imitates 3 actions						
Locate daily room						
Additional Notes:						
Previous rating: Today's rating:						

A-25

ADM Rating Criteria — Sample Page from Specific Craft Activity Rating Criteria. (Shown here: Canvas Place Mat). In addition to the general rating criteria, specific rating criteria have been established for each of the 35 craft activities in the ADM module. Each activity contains a complete chapter outlining Mode, Behavior and Prompts for the complete cognitive range for which that activity is suitable to evaluate. This brief sample page illustrates Modes 3.4 and 3.6 for the Canvas Place Mat activity.

	Fringe Shapes	**Rating Criteria – CU-8: Place Mat (3.0 – 4.6)**	
		Mode	**Behavior Prompts**
3.4	•	May begin to place shapes without instruction/fails to wait when asked.	"Put it here."
	• •	Actions on objects are sustained one minute longer.	Place hand over hand and guide placement of shape.
	• •	Looks at shapes/mat inconsistently, does not note whether shapes are adhering. May not use glue, threads are incompletely removed from mat.	"Keep going."
	•	May pull out 1 or 2 threads but abandons quickly at first difficulty. Cannot imitate different ways of pulling thread.	"Look at what you are doing."
	•	Dots glue on shape or on mat and places randomly. Shapes may be placed in rows. Does not adjust place mat in attempt to fill mat. May quit at any time or when shapes are used up.	Point to objects. Put glue on shape and hand to person (compensation).
	•	May use excessive/insufficient glue without awareness of effect.	"Can you wait for directions?"
		Does not request assistance/instruction.	"Look here: is the string off? Is the shape sticking?"
		15 to 30 minutes; slow/episodic.	"Place the shape here" (point to location).
3.6	•	May begin to place shapes without instruction, but waits for instructions when told.	"Try to grab one thread at a time."
	• •	Looks at/notes effects of actions, and may comment on effect ("This is not working").	
	•	May pull out a few threads on 1 or 2 sides but stops at first difficulty or yanks harder. May be able to imitate demonstration to pull one thread at a time but usually abandons after a few attempts.	
	•	Dots glue on shape and places on mat in own "design," which may appear random. Shapes are picked up and repositioned. May place along edge of mat to make a "border." Does not refer to sample. May quit at any time or when shapes are used up.	

`Routine Task Inventory (RTI)`. Two pages of the Routine Task Inventory are included here for your review. The RTI is used to set short- and long-terms goals, make discharge recommendations, consult with long-term caregivers and advocate for healthcare reform. The complete RTI is listed in *Occupational Therapy Treatment Goals for the Physically and Cognitively Disabled*, 1992, American Occupational Therapy Association, available through S&S® Worldwide.

Routine Task Inventory-2 – Sample Page

Routine Task Inventory-2 (RTI-2) Score Codes

S = Self-report
C = Caregiver report
O = Observation of performance
NA = Not applicable
NT = Not tested

Score: The number recorded is the cognitive level. The therapist records the self-report and caregiver report as described.

	S	C	O		S	C	O
Grooming				Housekeeping			
Dressing				Getting food			
Bathing				Spending money			
Walking/exercising				Shopping			
Eating				Doing laundry			
Toileting				Traveling			
Taking medicines				Telephoning			
Using adaptive				Adjusting to change			
Major role				Communicating			
Spare time				Following instructions			
Pacing/timing				Family activities			
Exerting effort				Dependents			
Judging results				Cooperating			
Speaking				Supervising			
Safety precautions				Keeping informed			
Emergency response				Citizenship			

Routine Task Inventory — Sample Page

Chapter 4: Evaluation Instruments

Questions for Self-Report Based on Routine Task Inventory

Format

1. What does the activity consist of?
2. Frequency of activity?
3. Assistance required to complete the activity?
4. Social consequences of activity as performed?
5. Patient's awareness of social consequences?

Physical Scale

A. Grooming
1. "What does your grooming consist of?"
2. "How often do you do these things?"
3. "Do others help you with any of these things?"
4. "Does anyone ever complain about your grooming/how you look/smell?"
5. "Do you agree with these complaints?"

B. Dressing
1. "How do you decide what to wear each day?"
2. "Are there days when you don't get dressed?"
3. "Does anyone help you decide what to wear or help you get dressed?"
4. "Does anyone ever complain about your clothes?"
5. "Do you agree with them?"

C. (Women only)
1. "What do you do to care for your menstrual flow?"
2. "How often do you change it?" "How often do you bathe during your period?"

D. Walking
1. "Where do you walk during the day?" "Do you ever go to new places?"
2. "How often?"
3. "Do you need help in finding new or familiar places?"
4. "Does anyone ever complain about you getting lost?"
5. "Do you think this is a problem?"

E. Feeding
1. "What does your diet consist of?" "Are you on a special diet?"
2. "How often do you eat?"
3. "Does anyone have to help you in any way during a meal?"
4. "Does anyone ever complain about your table manners?"
5. "Do you agree with these complaints?"

F. Toileting
1. "What do you do about going to the bathroom?" "How do you find a bathroom in a new place?"
2. "Does anyone help you in any way to use the toilet?"
3. "Does anyone ever complain about you failing to flush the toilet/not making it to the bathroom/urinating in a public place?"
4. "Do you think these things are problems?"

Instrumental Scale

A. Housekeeping
1. "What do you do (at home/board and care) to keep your place/things clean?" (Transients: "What do you do when your blankets get dirty?")
2. "How often do you do these things?"
3. "Does anyone help you clean your room or straighten your things?"
4. "Does anyone ever complain about how your place/room looks?" "Have you ever been evicted for not taking care of your place?"
5. "Do you agree with these complaints?"

B. Preparing/Securing Food
1. "How do you get your food?" Board and care: "How do you know when meals are served?" Cooks for self: "How do you heat things?" "Have you had trouble with burns/cutting yourself/setting fires?" Eats out: "Where do you eat?" "What is a typical order?"
2. "How often do you eat each day?"
3. "Does anyone ever help you with food preparation?" Board and care: "Do you have to be called to dinner?"

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