

Bell's Functionality Score (Disability Scale Assessment)

PATIENT'S NAME: _____ DATE: _____

Place an X in the box next to that which mostly describes how well you are functioning overall today

Bell's Functionality Score

100	Fully recovered. Normal activity level with no symptoms	<input type="checkbox"/>
90	Normal activity with mild symptoms at times	<input type="checkbox"/>
80	Near normal activity with some symptoms	<input type="checkbox"/>
70	Able to work full time but with difficulty. Mostly mild symptoms	<input type="checkbox"/>
60	Able to do about 6-7 hours of work a day. Mostly mild to moderate symptoms	<input type="checkbox"/>
50	Able to do about 4-5 hours of work or similar activity at home. Symptoms mostly moderate. Daily rests required	<input type="checkbox"/>
40	Able to leave house every day. Moderate symptoms on average. Able to do about 3-4 hours a day of work or activity like housework, shopping, using computer	<input type="checkbox"/>
30	Able to leave the house several times a week. Moderate to severe symptoms much of the time. Able to do about 2 hours a day of work at home or activity like housework, shopping, using computer	<input type="checkbox"/>
20	Able to leave house once or twice a week. Moderate to severe symptoms. Able to concentrate for one hour or less per day	<input type="checkbox"/>
10	Mostly bedridden. Severe symptoms	<input type="checkbox"/>
0	Bedridden constantly. Unable to care for self	<input type="checkbox"/>

Staff to complete:

NOTES:

ASSESSMENT CARRIED OUT BY: _____