Questionnaire on loss of ability

These questions are intended to clarify various factors regarding physical and mental capabilities. Next to each section is a field where you can describe in your own words how your illness or disability affects your capability to perform various daily functions (that you must perform most days or every day).

If you need help answering the questionnaire, you should get someone else to write down the answers for you (but answer in your own words!).

Where can the applicant be contacted in the next two months?

1. Name of applicant		2. ID No.
3. Address	4. Post code	5. Municipality
6. Home phone/Mobile/Work phone no.	7. E-mail	
8. A physician who I believe is most familiar with my health	9. Family physician, if not the same as in item 8	

For those who fill out the questionnaire on another's behalf (assistants)

10. Why have you assisted the applicant?

11. Name of assistant		12. ID No.
13. Address	14. Post code	15. Municipality

When you have completed and signed the questionnaire, you must send it, along with your application (if an application has NOT already been sent), to the Social Insurance Administration. The address should read:

Tryggingastofnun
Hlíðasmára 11
201 Kópavogur

16. Short description of the health problem:

17. Hospitalizations, surgeries, major accidents:

18. Pending medical treatment in the next few months:

19. What has been your main line of work and for approximately how long?

Id-number:

20. What was your last paid employment and what was it?

21. Education, special occupational qualifications (e.g. vocational qualifications, captain's licence, any kind of occupational licensing):

22. Are you married/cohabiting? ☐ No ☐ Yes

Are you supporting children under the age of 18? Number, age:

Expecting a child/children? ☐ No ☐ Yes When?

Particular loss of ability

1. Sitting on a chair (i.e. a chair with a back but no arms)

☐ I have no difficulty sitting

Please describe further if sitting is difficult for you:

2. Standing up from a chair (to stand up from a "dining room chair" with a back but no arms)

☐ I have no difficulty standing up from a chair

Please describe further if standing up from a chair is difficult for you:

3. Bending or kneeling

☐ I have no difficulty bending or kneeling, picking up a small object from the floor and straightening myself

Please describe further if bending or kneeling is difficult for you:

4. Standing

☐ I have no difficulty standing

Please describe further if standing is difficult for you:

5. Walking on level ground

If you normally use one or two canes or crutches, a walking frame or similar equipment, you should presume the use of these aids when describing how you walk.

☐ I have no difficulty walking

Please describe further if walking is difficult for you:

Id-number:

6. Walking up and down stairs (in an apartment building)

☐ I have no difficulty walking up and down stairs

Please describe further if walking up and down stairs is difficult for you:

7. Using your hands

☐ I have no difficulty using my hands

Please describe further if using your hands is difficult for you:

8. Reaching for objects

☐ I have no difficulty reaching for objects

Please describe further if reaching for objects is difficult for you:

9. Lifting and carrying

☐ I have no difficulty lifting and carrying objects

Please describe further if lifting and carrying is difficult for you:

10. Eyesight

This refers to seeing things in a normal light, outside in daylight or inside with good electrical lighting. Describe your eyesight **with glasses** if you use them normally.

☐ My eyesight does not bother me

Please describe further if your eyesight is poor:

11. Speech

☐ I have no difficulty speaking

Please describe further if you have difficulty speaking:

12. Hearing

If you use a hearing aid, describe your hearing **with the hearing aid.**

☐ My hearing does not bother me

Please describe further if your hearing is poor:

13. Loss of consciousness

These refer to seizures or comparable loss or lack of consciousness during waking hours. This does not apply to the effects of intoxicants, dizzy spells or fits of rage.

☐ I have not had any problems due to loss of consciousness

Id-number:

Please describe further if you have lost consciousness (see description above):

14. Bowel movements and urination

This refers to the involuntary discharge of faeces or urine before reaching the toilet. This does not refer to urination in your sleep or minor urinary incontinence, e.g. during bodily exercise.

15. Control of bowel movements

☐ I have no difficulty controlling my bowel movements

Please describe further if you have difficulty controlling your bowel movements:

16. Control of urination

☐ I have no difficulty controlling my urination

Please describe further if you have difficulty controlling your urination:

17. Mental problems

Have you had any mental problems? ☐ No ☐ Yes

Further description if the applicant so desires:

18. Signature

Place	Date
Signature of applicant	