

# IHSS ASSESSMENT WORKSHEET

Do you need help with these activities?	Yes or No	Please Mark The Level of Help Needed				How many minutes of help each day?
		Need verbal reminder	Can do, but need help	Can do with lots of help	Cannot do at all	
Breathing assistance: oxygen, nebulizer, other breathing equipment						
Toileting: on/off toilet, cleaning up, diapers						
Eating or drinking						
Taking a bath in bed						
Dressing						
Walking or moving in wheelchair						
Moving in/out of bed or chair						
Taking a shower or bath						
Brushing hair						
Brushing Teeth						
Putting on braces or special equipment						
Shaving						
Circulation massage						
Range of motion or strengthening exercises						
Repositioning						
Checking blood sugar levels						
Injecting insulin						
Taking medicine						
<b>If you need to be watched all the time because it is dangerous if you are alone, ask for protective supervision.</b>						