

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 you 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