PROFILE OF PARTICIPATION (PoP)
–
Participation in Activities of Daily Living & Performance Patterns

Name		**Medical Record #**	
Date of Birth		**Age**	
Gender		**Race/ethnicity**	
Marital Status		**Date of Assessment**	

Table of Contents

Client name: _____ Medical Record #: _____

I. HOUSING & COMMUNITY INTEGRATION

1. On a scale of 1-5, how satisfied are you with your housing situation?

1	2	3	4	5
Very unsatisfied	Unsatisfied	Neutral	Satisfied	Very satisfied

Why? Please explain:

2. To what extent do you feel like you 'fit in' there? In other words, to what extent do you feel like you belong?

1	2	3	4	5
I never 'fit in'	Sometimes I 'fit in'	Neutral	I usually 'fit in'	I always 'fit in'

Why? Please explain:

3. How did you end up in the place where you live right now? Where else have you lived?

4. Please list at least 3 things that are important to you in a place to live.

1. 4.
2. 5.
3. 6.

5. How much do you want to change your housing situation?

1	2	3	4	5
Not at all	Slightly	Moderately	Very	Extremely

[*For scores 3-5, ask*] Where do you want to live? Why?

What ideas do you have about how you could change your living situation? Who could help?

6. Name 2-3 places in the community that you visit regularly:

Places	**How often do you visit it?** Examples: • Everyday • Once a week • Once a month	**What do you do there?**	**How important is this place to you?** 1) Very important 2) Important 3) Moderately important 4) Slightly important 5) Not important
1.			
2.			
3.			

Comments:

7. Name 2-3 places in the community you *would like* to visit

Places	**Why?**	**How often would you like to go there?** Examples: • Everyday • Once a week • Once a month	**What is stopping you from going there?**
1.			
2.			
3.			

Comments:

II. HEALTH & SAFETY

1. To what extent is your physical health important to you?

1	2	3	4	5
Not important	Slightly important	Moderately important	Important	Very important

Comments**:**

2. How good are you at taking care of these healthcare needs on your own?

Task	Skill Level – Level of Proficiency					Is this activity important to you?		
	I don't know how to do this	I need help with this	I'm average at this	I'm good at this	I'm very good at this	Yes	No	I want to do it
Eating healthy								
Exercise								
Pain management								
Good sleep habits								
Safer sex practices								
Scheduling/attending medical appointments								
Understanding what my doctor &/or other healthcare professionals tell me								
Taking medication as prescribed								
Using mobility device or adaptive equipment								
Other:								

Comments:

3. Do you have any healthcare needs that you would like to get better at taking care of? ☐ Yes ☐ No

[*If YES*] What are they?

4. Can you give me an example of an emergency you've experienced?

5. What did you do? Would you do the same thing today?

6. How skilled are you at the following safety procedures and emergency responses?

Task	**Skill Level – Level of Proficiency**					**Is this activity important to you?**		
	I don't know how to do this	I need help with this	I'm average at this	I'm good at this	I'm very good at this	Yes	No	I want to do it
Fire escape plan								
How to respond to experiencing a fall								
When/how to call for help (911 or Police)								
Where to locate & how to use a fire extinguisher								
How to use & maintain safety devices (smoke & carbon monoxide alarms)								

How to seek shelter in inclement weather								
Home security (e.g., locking doors)								
Reading warning labels on chemicals & food								
Knowing which cleaning supplies to not mix								
Other:								

Comments:

7. Are there any safety procedures and emergency responses that you would like to get better at? ☐ Yes ☐ No

[*If YES*] What are they?

8. Do you own a firearm? ☐ Yes ☐ No

[*If YES*] Where do you store your firearm(s)?_____

[*If YES*] Are you interested in learning about firearm safety? ☐ Yes ☐ No

9. Are you good at setting boundaries with others (to avoid being taken advantage of)? ☐ Yes ☐ No

[*Examples: telling someone they can't stay at your place for too many days; refusing to let someone borrow your money, etc.*]

[*If NO*] Are you interested in learning about how to set boundaries with others to avoid being taken advantage of? ☐ Yes ☐ No

Comments:

III. SOCIAL SUPPORTS

1. Please name 3-5 people in your life. ___ I don't have any social supports

Name	What is your relationship with this person? (family, friend, coworker, significant other, etc.)?	Is this person supportive? Why or why not? (ex: yes, somewhat, no, etc.)	What activities do you do together?	How often do you talk to this person? (ex: every day, once a week, once a month, etc.)
1.				
2.				
3.				
4.				
5.				

Comments:

2. On a scale from 1 to 5, how comfortable are you with communicating your needs to people who support you?

1	2	3	4	5
Very uncomfortable	Uncomfortable	Neutral	Comfortable	Very comfortable

Comments**:**

3. Are there people who used to be in your life you would like to reconnect with?

☐ Yes ☐ No ☐ Don't know

[*If YES, complete table*]

Name	What is your relationship with this person?	Where did you last meet?	When did you last meet?	What did you do together during your last meeting?

Comments:

IV. SOCIAL MEDIA & TECHNOLOGY

1. Do you use social media? ☐ Yes ☐ No

[*If YES*] What type of social media do you use (e.g., email, Facebook, Instagram, Twitter, etc.)?

[*If NO*] Are you interested in learning how to use social media? ☐ Yes ☐ No ☐ Don't know

[If YES] What type of social media would you like to learn?

2. Do you have access to a computer? ☐ Yes ☐ No

[*If YES*] What do you use it for?

[*If NO*] Are you interested in having access to a computer? ☐ Yes ☐ No

3. Do you have a cell phone? ☐ Yes ☐ No

[*If YES*] What kind of phone do you have? _____

What do you use your phone to do?_____

Are you interested in learning how to use your phone better (e.g., texting, checking voicemail, etc.)? ☐ Yes ☐ No

[*If NO*] Are you interested in having a cell phone? ☐ Yes ☐ No

Comments:

V. HABITS & ROUTINES – What do you *do* on a regular basis?

1. Describe your daily routine on a typical day:

[*Try record as many activities as possible*]

Morning		Afternoon/Evening	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Comments:

2. How satisfied are you with your daily routine?

1	2	3	4	5
Very unsatisfied	Unsatisfied	Neutral	Satisfied	Very satisfied

[*If LESS THAN SATISFIED*] What could improve your satisfaction?

VI. CLIENT PRIORITIES FOR PARTICIPATION – What do you *want to do*?

1. Please list the 5 activities that are the *most important* to you.

Think about things you want or need to do.

Activity	How often do you do it? Examples: • Everyday • Once a week • Once a month	How well do you do it? • I'm very good at it • I'm good at it • Average • I'm not good at it • I'm terrible at it	Do you want to improve how well you do it? [If YES] What would you like to work on?
1.			
2.			
3.			
4.			
5.			

Comments:

2. Which activities would you like to do, but are not doing right now?

VII. SUPPORTS & BARRIERS TO PARTICIPATION

1. What supports help you do the things you want or need to do?
[*Consider the activities in question # 1 & 2 in Chapter VI. Client Priorities for Participation*]
[*Supports can be environmental, financial, personal, social, etc*.]

2. What makes it harder to do the things you want or need to do?
These would be considered barriers.
[*Barriers can be environmental, financial, personal, social, etc*.]

VIII. DESIRE TO LEARN NEW SKILLS

1. In each of the following areas, what steps are you taking to make changes in your life?

☐ I'm not trying to make changes to my life

Taking care of myself	Home	Work & School	Spending time with other people	Doing activities in the community	Getting around the community (e.g. car, bus, taxi, etc.)	Money	Health & Safety	Other

Comments:

2. In each of the following areas, are there any *NEW SKILLS you would like to learn* to be more successful and satisfied in the home and in the community?

☐ I'm not trying to make changes to my life

Taking care of myself	Home	Work & School	Spending time with other people	Doing activities in the community	Getting around the community (e.g. car, bus, taxi, etc.)	Money	Health & Safety	Other

Comments:

3. What can we do to support you in learning those skills?

Client name: _____ Medical Record #: _____

IX. EMPLOYMENT & EDUCATION

1. Are you currently going to school? ▭ Yes ▭ No

[*If YES*] What are you stuyding?_____

Where are you studying?_____

On a scale of 1-5, how satisfied are you with your education?

1	2	3	4	5
Very unsatisfied	Unsatisfied	Neutral	Satisfied	Very satisfied

Why? Please explain:

[*If NO*] *Would* you like to go back to school? ▭ Yes ▭ No ▭ Don't know

[*If YES*] What would you like to study? Why?

[*If I DON'T KNOW*] It sounds like you are unsure about going back to school. What does going back to school mean to you?

Why might going back to school sound like a *good* idea?

Why might going back to school sound like a *bad* idea?

2. Are you currently employed? ▭ Yes ▭ No

[*If YES*] Where do you work?_____

On a scale of 1-5, how satisfied are you with your work?

1	2	3	4	5
Very unsatisfied	Unsatisfied	Neutral	Satisfied	Very satisfied

Why? Please explain:

[*If NO*] Are you interested in work? ▭ Yes ▭ No

[If YES] What type of work are you interested in?

[If NO] Why not?

Client name: _____ Medical Record #: _____

X. FINANCIAL MANAGEMENT

1. Do you manage your own money? ▭ Yes ▭ No

Are you satisfied with your level of control over your money? ▭ Yes ▭ No

2. How do you pay bills? (circle one)

I don't pay bills Cash Money Order Check Debit card Credit card

3. How skilled are you at the following money management tasks?

Task	Skill Level – Level of Proficiency					Is this activity important to you?		
	I don't know how to do this	I need help with this	I'm average at this	I'm good at this	I'm very good at this	Yes	No	I want to do it
Counting money to buy something								
Counting change to make sure you got the right amount back								
Writing a check								
Using money orders								
Paying bills								
Budgeting (planning your expenses & income)								
Using an ATM								
Managing records								
Talking on the phone to ask about bills/payment options								
Protecting personal information (SSN, ID, Account numbers)								
Reading a sales receipt								
Keeping your money safe								
Other:								

Comments:

4. Are there any money management tasks that you would like to get better at? ▭ Yes ▭ No

[*If YES*] What would you like to work on?

XI. HOME MANAGEMENT

1. How do you get food?

2. Do you cook for yourself? ▭ Yes ▭ No

[*If YES*] How often?

_____

[*If YES*] What do you like to cook?_____

[*If NO*] Why not?_____

3. How skilled are you at the following cooking tasks?

Task	Skill Level – Level of Proficiency					Is this activity important to you?		
	I don't know how to do this	I need help with this	I'm average at this	I'm good at this	I'm very good at this	Yes	No	I want to do it
Meal planning								
Grocery shopping								
Using coupons/discounts								
Using the stove								
Using the oven								
Using the microwave								
Using a toaster								
Using a knife to cut food								
Cooking meat or chicken								
Cooking frozen meals								
Cooking boxed foods								
Cooking a meal from scratch								
Following directions of a recipe								
Serving healthy portions								
Using expiration & sell by dates								
Understanding nutrition facts								
Food storage (e.g. what foods need to be stored in a refrigerator)								
Food safety (e.g., how to know when food has spoiled and is no longer safe to eat)								
Other:								

Comments:

4. Are there any cooking tasks that you would like to get better at? ☐ Yes ☐ No

[*If YES*] What would you like to work on?

5. Do you do your own laundry? ☐ Yes ☐ No

[*If YES*] How often?

_____

[*If* YES]
Where?_____

[*If NO*] Why
not?_____

[*If NO*] Do you have access to a washing machine and dryer? ☐ Yes ☐ No

6. How skilled are you at the following laundry tasks?

Task	Skill Level – Level of Proficiency					Is this activity important to you?		
	I don't know how to do this	I need help with this	I'm average at this	I'm good at this	I'm very good at this	Yes	No	I want to do it
Using the washing machine								
Knowing how much detergent to put in the washing machine								
Using the dryer								
Folding clothes								
Putting clothes in my closet/dresser								
Ironing clothes								
Using a dirty clothes bin								
Knowing when an item can be worn again or needs to be cleaned								
Other:								

Comments:

7. Are there any laundry tasks that you would like to get better at? ☐ Yes ☐ No

[*If YES*] What would you like to work on?

8. Do you clean your own home? ☐ Yes ☐ No

[*If YES*] How often?

_____

9. How skilled are you at the following cleaning tasks?

Task	Skill Level – Level of Proficiency					Is this activity important to you?		
	I don't know how to do this	I need help with this	I'm average at this	I'm good at this	I'm very good at this	Yes	No	I want to do it
Dusting								
Vacuuming								
Mopping								
Sweeping								
Cleaning the bathroom								
Taking out the trash/recycling								
Picking/cleaning up personal items								
Hand-washing dishes								
Using the dishwasher								
Knowing how much detergent to use								
Putting dishes away								
Using a garbage disposal								
Using cleaning products								
Disposing of grease								
Other:								

Comments:

10. Are there any cleaning tasks that you would like to get better at? ☐ Yes ☐ No

[*If YES*] What would you like to work on?

11. Do you have access to cleaning supplies? ☐ Yes ☐ No

Client name: _____ Medical Record #: _____

Comments:

XII. LEISURE & SOCIAL PARTICIPATION

1. Please list 3-6 activities you do for fun or to relax.

Activity	How often?
1.	
2.	
3.	
4	
5.	
6.	
7.	

Comments:

2. Are there any activities *you would like to do* for fun or to relax?

Activity	Why are you not doing this activity?
1.	
2.	
3.	
4	
5.	
6.	
7.	

Comments:

3. What activities do you enjoy doing with other people? ☐ I don't enjoy doing activities with other people

1. 4.
2. 5.
3. 6.

If you don't enjoy doing activities with others, why not?

Client name: _____ Medical Record #: _____

XIII. COMMUNITY MOBILITY

1. How do you get around in the community?_____

Is getting around the community important to you? ☐ Yes ☐ No

2. Are you interested in learning new ways to get around the community? ☐ Yes ☐ No

3. How skilled are you at using the following modes of transportation to get around the community?

Task	Skill Level – Level of Proficiency					Is this activity important to you?		
	I don't know how to do this	I need help with this	I'm average at this	I'm good at this	I'm very good at this	Yes	No	I want to do it
Walking								
Taxi – Uber – Lyft								
Bicycle								
Bus								
Car								
Getting a ride from friends/family								
Other:								

Comments:

4. How satisfied are you with your ability to get around in the community?

1	2	3	4	5
Very unsatisfied	Unsatisfied	Neutral	Satisfied	Very satisfied

[*If LESS THAN SATISFIED*] What could improve your satisfaction?

XIV. QUALITY OF LIFE – LIFE SATISFACTION

1. On a scale of 1-5, how satisfied are you with your life?

1	2	3	4	5
Very unsatisfied	Unsatisfied	Neutral	Satisfied	Very satisfied

Why? Please explain:

2. Please list your personal strengths. What are you good at?

1. 5.
2. 6.
3.: 7.

Comments:

XV. DECISION MAKING

1. How much control do you have over important decisions in your life?

1	2	3	4	5
No control	Very little control	Some control	A lot of control	Total control

Comments:

2. To what extent do you want help making important decisions that affect your life?

1	2	3	4	5
I don't want help	I want very little help	I want some help	I want a lot of help	I always want help

Comments:

What are some important decisions you have made?

1. 4.
2. 5.
3. 6.

Comments:

XVI. Additional Information

Is there anything else would you like to add that would help us help you?

XVII. Recommendations:

ACT Staff: _____

Date: _____