

# ICF-based Documentation Form

Reminder: The categories of the Generic Set are indicated by the letter (G).

|                            |
|----------------------------|
| <b>PATIENT INFORMATION</b> |
|                            |

| BODY FUNCTIONS                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | No impairment            | Mild impairment          | Moderate impairment      | Severe impairment        | Complete impairment      | Not specified            | Not applicable           |
|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Physiological functions of body systems (including psychological functions) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| How much impairment does the person have in ...                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                          |                          |                          |                          |                          |                          |                          |
| b130                                                                        | <b>Energy and drive functions (G)</b><br><b>General mental functions of physiological and psychological mechanisms that cause the individual to move towards satisfying specific needs and general goals in a persistent manner.</b><br>Inclusions: functions of energy level, motivation, appetite, craving (including craving for substances that can be abused) and impulse control<br>Exclusions: consciousness functions (b110); temperament and personality functions (b126); sleep functions (b134); psychomotor functions (b147); emotional functions (b152)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b134                                                                        | <b>Sleep functions</b><br><b>General mental functions of periodic, reversible and selective physical and mental disengagement from one's immediate environment accompanied by characteristic physiological changes.</b><br>Inclusions: functions of amount of sleeping, and onset, maintenance and quality of sleep; functions involving the sleep cycle, such as in insomnia, hypersomnia and narcolepsy<br>Exclusions: consciousness functions (b110); energy and drive functions (b130); attention functions (b140); psychomotor functions (b147)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b152                                                                        | <b>Emotional functions (G)</b><br><b>Specific mental functions related to the feeling and affective components of the processes of the mind.</b><br>Inclusions: functions of appropriateness of emotion, regulation and range of emotion; affect; sadness, happiness, love, fear, anger, hate, tension, anxiety, joy, sorrow; lability of emotion; flattening of affect<br>Exclusions: temperament and personality functions (b126); energy and drive functions (b130)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b180                                                                        | <b>Experience of self and time functions</b><br><b>Specific mental functions related to the awareness of one's identity, one's body, one's position in the reality of one's environment and of time.</b><br>Inclusions: functions of experience of self, body image and time<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b1801                                                                       | <b>Body image</b><br><b>Specific mental functions related to the representation and awareness of one's body.</b><br>Inclusion: impairments such as phantom limb and feeling too fat or too thin<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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| <b>b280</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Sensation of pain (G)</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Sensation of unpleasant feeling indicating potential or actual damage to some body structure.</b><br>Inclusions: sensations of generalized or localized pain in one or more body part, pain in a dermatome, stabbing pain, burning pain, dull pain, aching pain; impairments such as myalgia, analgesia and hyperalgesia<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b> |                              |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b2800</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Generalized pain</b>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Sensation of unpleasant feeling indicating potential or actual damage to some body structure felt all over, or throughout the body.</b><br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                                  |                              |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b2801</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <b>Pain in body part</b>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Sensation of unpleasant feeling indicating potential or actual damage to some body structure felt in a specific part, or parts, of the body.</b><br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                         |                              |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b28010</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Pain in head and neck</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Sensation of unpleasant feeling indicating potential or actual damage to some body structure felt in the head and neck.</b><br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                                              |                              |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b28013</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Pain in back</b>          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Sensation of unpleasant feeling indicating potential or actual damage to some body structure felt in the back.</b><br>Inclusions: pain in the trunk; low backache<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                        |                              |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b28014</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Pain in upper limb</b>    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Sensation of unpleasant feeling indicating potential or actual damage to some body structure felt in either one or both upper limbs, including hands.</b><br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                |                              |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                              | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b28015</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <b>Pain in lower limb</b>    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Sensation of unpleasant feeling indicating potential or actual damage to some body structure felt in either one or both lower limbs, including feet.</b><br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                 |                              |                          |                          |                          |                          |                          |                          |                          |

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|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b28016</b> | <b>Pain in joints</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|               | <b>Sensation of unpleasant feeling indicating potential or actual damage to some body structure felt in one or more joints, including small and big joints.</b><br>Inclusions: pain in the hip; pain in the shoulder<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                |                          |                          |                          |                          |                          |                          |                          |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b430</b>   | <b>Haematological system functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|               | <b>Functions of blood production, oxygen and metabolite carriage, and clotting.</b><br>Inclusions: functions of the production of blood and bone marrow; oxygen-carrying functions of blood; blood-related functions of spleen; metabolite-carrying functions of blood; clotting; impairments such as in anaemia, haemophilia and other clotting dysfunctions<br>Exclusions: functions of the cardiovascular system (b410-b429); immunological system functions (b435); exercise tolerance functions (b455)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                         |                          |                          |                          |                          |                          |                          |                          |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b455</b>   | <b>Exercise tolerance functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|               | <b>Functions related to respiratory and cardiovascular capacity as required for enduring physical exertion.</b><br>Inclusions: functions of physical endurance, aerobic capacity, stamina and fatigability<br>Exclusions: functions of the cardiovascular system (b410-b429); haematological system functions (b430); respiration functions (b440); respiratory muscle functions (b445); additional respiratory functions (b450)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                    |                          |                          |                          |                          |                          |                          |                          |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b510</b>   | <b>Ingestion functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|               | <b>Functions related to taking in and manipulating solids or liquids through the mouth into the body.</b><br>Inclusions: functions of sucking, chewing and biting, manipulating food in the mouth, salivation, swallowing, burping, regurgitation, spitting and vomiting; impairments such as dysphagia, aspiration of food, aerophagia, excessive salivation, drooling and insufficient salivation<br>Exclusion: sensations associated with digestive system (b535)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                |                          |                          |                          |                          |                          |                          |                          |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b640</b>   | <b>Sexual functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|               | <b>Mental and physical functions related to the sexual act, including the arousal, preparatory, orgasmic and resolution stages.</b><br>Inclusions: functions of the sexual arousal, preparatory, orgasmic and resolution phase: functions related to sexual interest, performance, penile erection, clitoral erection, vaginal lubrication, ejaculation, orgasm; impairments such as in impotence, frigidity, vaginismus, premature ejaculation, priapism and delayed ejaculation<br>Exclusions: procreation functions (b660); sensations associated with genital and reproductive functions (b670)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b> |                          |                          |                          |                          |                          |                          |                          |
|               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b710</b>   | <b>Mobility of joint functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|               | <b>Functions of the range and ease of movement of a joint.</b><br>Inclusions: functions of mobility of single or several joints, vertebral, shoulder, elbow, wrist, hip, knee, ankle, small joints of hands and feet; mobility of joints generalized; impairments such as in hypermobility of joints, frozen joints, frozen shoulder, arthritis<br>Exclusions: stability of joint functions (b715); control of voluntary movement functions (b760)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                  |                          |                          |                          |                          |                          |                          |                          |

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| <b>b7102</b> | <b>Mobility of joints generalized</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | <b>Functions of the range and ease of movement of joints throughout the body.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                          |                          |                          |                          |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b715</b>  | <b>Stability of joint functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | <b>Functions of the maintenance of structural integrity of the joints.</b><br>Inclusions: functions of the stability of a single joint, several joints, and joints generalized; impairments such as in unstable shoulder joint, dislocation of a joint, dislocation of shoulder and hip<br>Exclusion: mobility of joint functions (b710)                                                                                                                                                                                                                                                                                 |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                          |                          |                          |                          |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b730</b>  | <b>Muscle power functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | <b>Functions related to the force generated by the contraction of a muscle or muscle groups.</b><br>Inclusions: functions associated with the power of specific muscles and muscle groups, muscles of one limb, one side of the body, the lower half of the body, all limbs, the trunk and the body as a whole; impairments such as weakness of small muscles in feet and hands, muscle paresis, muscle paralysis, monoplegia, hemiplegia, paraplegia, quadriplegia and akinetic mutism<br>Exclusions: functions of structures adjoining the eye (b215); muscle tone functions (b735); muscle endurance functions (b740) |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                          |                          |                          |                          |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b740</b>  | <b>Muscle endurance functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | <b>Functions related to sustaining muscle contraction for the required period of time.</b><br>Inclusions: functions associated with sustaining muscle contraction for isolated muscles and muscle groups, and all muscles of the body; impairments such as in myasthenia gravis<br>Exclusions: exercise tolerance functions (b455); muscle power functions (b730); muscle tone functions (b735)                                                                                                                                                                                                                          |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                          |                          |                          |                          |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b770</b>  | <b>Gait pattern functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | <b>Functions of movement patterns associated with walking, running or other whole body movements.</b><br>Inclusions: walking patterns and running patterns; impairments such as spastic gait, hemiplegic gait, paraplegic gait, asymmetric gait, limping and stiff gait pattern<br>Exclusions: muscle power functions (b730); muscle tone functions (b735); control of voluntary movement functions (b760); involuntary movement functions (b765)                                                                                                                                                                        |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                          |                          |                          |                          |
|              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b780</b>  | <b>Sensations related to muscles and movement functions</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | <b>Sensations associated with the muscles or muscle groups of the body and their movement.</b><br>Inclusions: sensations of muscle stiffness and tightness of muscles, muscle spasm or constriction, and heaviness of muscles<br>Exclusion: sensation of pain (b280)                                                                                                                                                                                                                                                                                                                                                     |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                          |                          |                          |                          |                          |                          |                          |

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|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|              |                                                                                                                                                                                              | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>b7800</b> | <b>Sensation of muscle stiffness</b>                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|              | <b>Sensation of tightness or stiffness of muscles.</b>                                                                                                                                       |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Sources of information:</b>                                                                                                                                                               |                          |                          |                          |                          |                          |                          |                          |
|              | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                          |                          |                          |                          |                          |                          |                          |
|              | <b>Description of the problem:</b>                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |

| BODY STRUCTURES                                                                                                                                                                              |                                              |            | No impairment            | Mild impairment          | Moderate impairment      | Severe impairment        | Complete impairment      | Not specified            | Not applicable           |                          |                          |                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Anatomical parts of the body such as organs, limbs and their components                                                                                                                      |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| How much impairment does the person have in the ...                                                                                                                                          |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s299                                                                                                                                                                                         | Eye, ear and related structures, unspecified | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|                                                                                                                                                                                              |                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                              |                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sources of information:                                                                                                                                                                      |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                  |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s710                                                                                                                                                                                         | Structure of head and neck region            | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|                                                                                                                                                                                              |                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                              |                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sources of information:                                                                                                                                                                      |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                  |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s720                                                                                                                                                                                         | Structure of shoulder region                 | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|                                                                                                                                                                                              |                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                              |                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sources of information:                                                                                                                                                                      |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                  |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s730                                                                                                                                                                                         | Structure of upper extremity                 | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|                                                                                                                                                                                              |                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                              |                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sources of information:                                                                                                                                                                      |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                  |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s73001                                                                                                                                                                                       | Elbow joint                                  | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|                                                                                                                                                                                              |                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|                                                                                                                                                                                              |                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                              |                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sources of information:                                                                                                                                                                      |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                  |                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |

|        |                                                                                                                                                                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s73011 | Wrist joint                                                                                                                                                                                  | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s7302  | Structure of hand                                                                                                                                                                            | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s73021 | Joints of hand and fingers                                                                                                                                                                   | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s73022 | Muscles of hand                                                                                                                                                                              | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s750   | Structure of lower extremity                                                                                                                                                                 | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |



|        |                                                                                                                                                                                              |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|--------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s75001 | Hip joint                                                                                                                                                                                    | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s75011 | Knee joint                                                                                                                                                                                   | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s7502  | Structure of ankle and foot                                                                                                                                                                  | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s760   | Structure of trunk                                                                                                                                                                           | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| s7600  | Structure of vertebral column                                                                                                                                                                | Extent     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              |            | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|        |                                                                                                                                                                                              | Nature*    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        |                                                                                                                                                                                              | Location** | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|        | Sources of information:                                                                                                                                                                      |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|        | Description of the problem:                                                                                                                                                                  |            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |

|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                |                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                |                   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| <b>s76000</b>                                                                                                                                                                                                                                                                                                                                                           | <b>Cervical vertebral column</b>                                                                                                                                                                                               | <b>Extent</b>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                |                   | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                | <b>Nature*</b>    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                | <b>Location**</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                         | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                         | <b>Description of the problem:</b>                                                                                                                                                                                             |                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                |                   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| <b>s770</b>                                                                                                                                                                                                                                                                                                                                                             | <b>Additional musculoskeletal structures related to movement</b>                                                                                                                                                               | <b>Extent</b>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                |                   | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                | <b>Nature*</b>    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                | <b>Location**</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                         | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                         | <b>Description of the problem:</b>                                                                                                                                                                                             |                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                |                   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |                          |                          |                          |
| <b>s810</b>                                                                                                                                                                                                                                                                                                                                                             | <b>Structure of areas of skin</b>                                                                                                                                                                                              | <b>Extent</b>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                |                   | 0                        | 1                        | 2                        | 3                        | 4                        | 5                        | 6                        | 7                        | 8                        | 9                        |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                | <b>Nature*</b>    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                | <b>Location**</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                         | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation |                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                         | <b>Description of the problem:</b>                                                                                                                                                                                             |                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <p>* 0=no change in structure, 1=total absence, 2=partial absence, 3=additional part, 4=aberrant dimension, 5=discontinuity, 6= deviating position, 7=qualitative changes in structure, 8=not specified, 9=not applicable</p> <p>** 0=more than one region, 1=right, 2=left, 3=both sides, 4=front, 5=back, 6=proximal, 7=distal, 8=not specified, 9=not applicable</p> |                                                                                                                                                                                                                                |                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |

| ACTIVITIES AND PARTICIPATION                                                                                                                                                                                                                                                                                                                                                                                      |                                            |   |                          |                          |                          |                          |                          |                          |                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Execution of a task or action by an individual and involvement in a life situation                                                                                                                                                                                                                                                                                                                                |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| How much difficulty does the person have in the ...                                                                                                                                                                                                                                                                                                                                                               |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| <b>P</b> = performance of ...<br><b>C</b> = capacity in ...                                                                                                                                                                                                                                                                                                                                                       |                                            |   | No difficulty            | Mild difficulty          | Moderate difficulty      | Severe difficulty        | Complete difficulty      | Not specified            | Not applicable           |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d170                                                                                                                                                                                                                                                                                                                                                                                                              | Writing                                    | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Using or producing symbols or language to convey information, such as producing a written record of events or ideas or drafting a letter.<br>Exclusion: learning to write (d145)                                                                                                                                                                                                                                  |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Sources of information:                                                                                                                                                                                                                                                                                                                                                                                           |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                                                                                                                                                                                                                                       |                                            |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d230                                                                                                                                                                                                                                                                                                                                                                                                              | Carrying out daily routine (G)             | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Carrying out simple or complex and coordinated actions in order to plan, manage and complete the requirements of day-to-day procedures or duties, such as budgeting time and making plans for separate activities throughout the day.<br>Inclusions: managing and completing the daily routine; managing one's own activity level<br>Exclusion: undertaking multiple tasks (d220)                                 |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Sources of information:                                                                                                                                                                                                                                                                                                                                                                                           |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                                                                                                                                                                                                                                       |                                            |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d360                                                                                                                                                                                                                                                                                                                                                                                                              | Using communication devices and techniques | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Using devices, techniques and other means for the purposes of communicating, such as calling a friend on the telephone.<br>Inclusions: using telecommunication devices, using writing machines and communication techniques                                                                                                                                                                                       |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Sources of information:                                                                                                                                                                                                                                                                                                                                                                                           |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                                                                                                                                                                                                                                       |                                            |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d410                                                                                                                                                                                                                                                                                                                                                                                                              | Changing basic body position               | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Getting into and out of a body position and moving from one location to another, such as getting up out of a chair to lie down on a bed, and getting into and out of positions of kneeling or squatting.<br>Inclusions: changing body position from lying down, from squatting or kneeling, from sitting or standing, bending and shifting the body's centre of gravity<br>Exclusion: transferring oneself (d420) |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Sources of information:                                                                                                                                                                                                                                                                                                                                                                                           |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                                                                                                                                                                                                                                       |                                            |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d415                                                                                                                                                                                                                                                                                                                                                                                                              | Maintaining a body position                | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                   |                                            | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Staying in the same body position as required, such as remaining seated or remaining standing for work or school.<br>Inclusions: maintaining a lying, squatting, kneeling, sitting and standing position                                                                                                                                                                                                          |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Sources of information:                                                                                                                                                                                                                                                                                                                                                                                           |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| <input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                                            |   |                          |                          |                          |                          |                          |                          |                          |
| Description of the problem:                                                                                                                                                                                                                                                                                                                                                                                       |                                            |   |                          |                          |                          |                          |                          |                          |                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| d430                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Lifting and carrying objects                                           | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Raising up an object or taking something from one place to another, such as when lifting a cup or carrying a child from one room to another.</b><br>Inclusions: lifting, carrying in the hands or arms, or on shoulders, hip, back or head; putting down<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                               |                                                                        |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d440                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Fine hand use                                                          | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Performing the coordinated actions of handling objects, picking up, manipulating and releasing them using one's hand, fingers and thumb, such as required to lift coins off a table or turn a dial or knob.</b><br>Inclusions: picking up, grasping, manipulating and releasing<br>Exclusion: lifting and carrying objects (d430)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                      |                                                                        |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d445                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Hand and arm use                                                       | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Performing the coordinated actions required to move objects or to manipulate them by using hands and arms, such as when turning door handles or throwing or catching an object</b><br>Inclusions: pulling or pushing objects; reaching; turning or twisting the hands or arms; throwing; catching<br>Exclusion: fine hand use (d440)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                   |                                                                        |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d449                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Carrying, moving and handling objects, other specified and unspecified | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                        |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d450                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Walking (G)                                                            | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Moving along a surface on foot, step by step, so that one foot is always on the ground, such as when strolling, sauntering, walking forwards, backwards or sideways.</b><br>Inclusions: walking short or long distances; walking on different surfaces; walking around obstacles<br>Exclusions: transferring oneself (d420); moving around (d455)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>      |                                                                        |   |                          |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        |   | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d455                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Moving around (G)                                                      | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Moving the whole body from one place to another by means other than walking, such as climbing over a rock or running down a street, skipping, scampering, jumping, somersaulting or running around obstacles.</b><br>Inclusions: crawling, climbing, running, jogging, jumping and swimming<br>Exclusions: transferring oneself (d420); walking (d450)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b> |                                                                        |   |                          |                          |                          |                          |                          |                          |                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| d460                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Moving around in different locations | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Walking and moving around in various places and situations, such as walking between rooms in a house, within a building or down the street of a town.</b><br>Inclusions: moving around within the home, crawling or climbing within the home; walking or moving within buildings other than the home, and outside the home and other buildings<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                                   |                                      |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d465                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Moving around using equipment        | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Moving the whole body from place to place, on any surface or space, by using specific devices designed to facilitate moving or create other ways of moving around, such as with skates, skis, or scuba equipment, or moving down the street in a wheelchair or a walker.</b><br>Exclusions: transferring oneself (d420); walking (d450); moving around (d455); using transportation (d470); driving (d475)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>       |                                      |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d470                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Using transportation                 | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Using transportation to move around as a passenger, such as being driven in a car or on a bus, rickshaw, jitney, animal-powered vehicle, or private or public taxi, bus, train, tram, subway, boat or aircraft.</b><br>Inclusions: using human-powered transportation; using private motorized or public transportation<br>Exclusions: moving around using equipment (d465); driving (d475)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                      |                                      |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d475                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Driving                              | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Being in control of and moving a vehicle or the animal that draws it, travelling under one's own direction or having at one's disposal any form of transportation, such as a car, bicycle, boat or animal-powered vehicle.</b><br>Inclusions: driving human-powered transportation, motorized vehicles, animal-powered vehicles<br>Exclusions: moving around using equipment (d465); using transportation (d470)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b> |                                      |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d510                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Washing oneself                      | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Washing and drying one's whole body, or body parts, using water and appropriate cleaning and drying materials or methods, such as bathing, showering, washing hands and feet, face and hair, and drying with a towel.</b><br>Inclusions: washing body parts, the whole body; and drying oneself<br>Exclusions: caring for body parts (d520); toileting (d530)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the problem:</b>                                                    |                                      |   |                          |                          |                          |                          |                          |                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
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| d520                                                                                                                                                                                                                                                                                                                                                                                                                                                | Caring for body parts | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Looking after those parts of the body, such as skin, face, teeth, scalp, nails and genitals, that require more than washing and drying.</b><br>Inclusions: caring for skin, teeth, hair, finger and toe nails<br>Exclusions: washing oneself (d510); toileting (d530)                                                                                                                                                                            |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                       |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d530                                                                                                                                                                                                                                                                                                                                                                                                                                                | Toileting             | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Planning and carrying out the elimination of human waste (menstruation, urination and defecation), and cleaning oneself afterwards.</b><br>Inclusions: regulating urination, defecation and menstrual care<br>Exclusions: washing oneself (d510); caring for body parts (d520)                                                                                                                                                                   |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                       |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d540                                                                                                                                                                                                                                                                                                                                                                                                                                                | Dressing              | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Carrying out the coordinated actions and tasks of putting on and taking off clothes and footwear in sequence and in keeping with climatic and social conditions, such as by putting on, adjusting and removing shirts, skirts, blouses, pants, undergarments, saris, kimono, tights, hats, gloves, coats, shoes, boots, sandals and slippers.</b><br>Inclusions: putting on or taking off clothes and footwear and choosing appropriate clothing |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                       |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d550                                                                                                                                                                                                                                                                                                                                                                                                                                                | Eating                | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Carrying out the coordinated tasks and actions of eating food that has been served, bringing it to the mouth and consuming it in culturally acceptable ways, cutting or breaking food into pieces, opening bottles and cans, using eating implements, having meals, feasting or dining.</b><br>Exclusion: drinking (d560)                                                                                                                        |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                       |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d560                                                                                                                                                                                                                                                                                                                                                                                                                                                | Drinking              | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                       | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Taking hold of a drink, bringing it to the mouth, and consuming the drink in culturally acceptable ways, mixing, stirring and pouring liquids for drinking, opening bottles and cans, drinking through a straw or drinking running water such as from a tap or a spring; feeding from the breast.</b><br>Exclusion: eating (d550)                                                                                                                |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                                                                                                                                                                                                      |                       |   |                          |                          |                          |                          |                          |                          |
| <b>Description of the problem:</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                       |   |                          |                          |                          |                          |                          |                          |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| d570                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Looking after one's health        | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Ensuring physical comfort, health and physical and mental well-being, such as by maintaining a balanced diet, and an appropriate level of physical activity, keeping warm or cool, avoiding harms to health, following safe sex practices, including using condoms, getting immunizations and regular physical examinations.</b></p> <p>Inclusions: ensuring one's physical comfort; managing diet and fitness; maintaining one's health</p> <p><b>Sources of information:</b></p> <p><input type="checkbox"/> Case history      <input type="checkbox"/> Patient reported questionnaire      <input type="checkbox"/> Clinical examination      <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                   | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d620                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Acquisition of goods and services | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Selecting, procuring and transporting all goods and services required for daily living, such as selecting, procuring, transporting and storing food, drink, clothing, cleaning materials, fuel, household items, utensils, cooking ware, domestic appliances and tools; procuring utilities and other household services.</b></p> <p>Inclusions: shopping and gathering daily necessities</p> <p>Exclusion: acquiring a place to live (d610)</p> <p><b>Sources of information:</b></p> <p><input type="checkbox"/> Case history      <input type="checkbox"/> Patient reported questionnaire      <input type="checkbox"/> Clinical examination      <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                 |                                   | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d630                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Preparing meals                   | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Planning, organizing, cooking and serving simple and complex meals for oneself and others, such as by making a menu, selecting edible food and drink, getting together ingredients for preparing meals, cooking with heat and preparing cold foods and drinks, and serving the food.</b></p> <p>Inclusions: preparing simple and complex meals</p> <p>Exclusions: eating (d550); drinking (d560); acquisition of goods and services (d620); doing housework (d640); caring for household objects (d650); caring for others (d660)</p> <p><b>Sources of information:</b></p> <p><input type="checkbox"/> Case history      <input type="checkbox"/> Patient reported questionnaire      <input type="checkbox"/> Clinical examination      <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p>                                                                                                                                                                                                                                                                                                                            |                                   | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d640                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Doing housework                   | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Managing a household by cleaning the house, washing clothes, using household appliances, storing food and disposing of garbage, such as by sweeping, mopping, washing counters, walls and other surfaces; collecting and disposing of household garbage; tidying rooms, closets and drawers; collecting, washing, drying, folding and ironing clothes; cleaning footwear; using brooms, brushes and vacuum cleaners; using washing machines, driers and irons.</b></p> <p>Inclusions: washing and drying clothes and garments; cleaning cooking area and utensils; cleaning living area; using household appliances, storing daily necessities and disposing of garbage</p> <p>Exclusions: acquiring a place to live (d610); acquisition of goods and services (d620); preparing meals (d630); caring for household objects (d650); caring for others (d660)</p> <p><b>Sources of information:</b></p> <p><input type="checkbox"/> Case history      <input type="checkbox"/> Patient reported questionnaire      <input type="checkbox"/> Clinical examination      <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p> |                                   | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d660                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Assisting others                  | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                   | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Assisting household members and others with their learning, communicating, self-care, movement, within the house or outside; being concerned about the well-being of household members and others.</b></p> <p>Inclusions: assisting others with self-care, movement, communication, interpersonal relations, nutrition and health maintenance</p> <p>Exclusion: remunerative employment (d850)</p> <p><b>Sources of information:</b></p> <p><input type="checkbox"/> Case history      <input type="checkbox"/> Patient reported questionnaire      <input type="checkbox"/> Clinical examination      <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                   | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |

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| d760                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Family relationships                                 | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Creating and maintaining kinship relationships, such as with members of the nuclear family, extended family, foster and adopted family and step-relationships, more distant relationships such as second cousins or legal guardians.</b><br/> Inclusions: parent-child and child-parent relationships, sibling and extended family relationships</p> <p><b>Sources of information:</b><br/> <input type="checkbox"/> Case history    <input type="checkbox"/> Patient reported questionnaire    <input type="checkbox"/> Clinical examination    <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p>                                                                                                                     |                                                      |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d770                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Intimate relationships                               | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Creating and maintaining close or romantic relationships between individuals, such as husband and wife, lovers or sexual partners.</b><br/> Inclusions: romantic, spousal and sexual relationships</p> <p><b>Sources of information:</b><br/> <input type="checkbox"/> Case history    <input type="checkbox"/> Patient reported questionnaire    <input type="checkbox"/> Clinical examination    <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p>                                                                                                                                                                                                                                                                   |                                                      |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d850                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Remunerative employment (G)                          | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Engaging in all aspects of work, as an occupation, trade, profession or other form of employment, for payment, as an employee, full or part time, or self-employed, such as seeking employment and getting a job, doing the required tasks of the job, attending work on time as required, supervising other workers or being supervised, and performing required tasks alone or in groups.</b><br/> Inclusions: self-employment, part-time and full-time employment</p> <p><b>Sources of information:</b><br/> <input type="checkbox"/> Case history    <input type="checkbox"/> Patient reported questionnaire    <input type="checkbox"/> Clinical examination    <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p> |                                                      |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d859                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Work and employment, other specified and unspecified | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Sources of information:</b><br/> <input type="checkbox"/> Case history    <input type="checkbox"/> Patient reported questionnaire    <input type="checkbox"/> Clinical examination    <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                      |   |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | 0 | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| d910                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Community life                                       | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Engaging in all aspects of community social life, such as engaging in charitable organizations, service clubs or professional social organizations.</b><br/> Inclusions: informal and formal associations; ceremonies<br/> Exclusions: non-remunerative employment (d855); recreation and leisure (d920); religion and spirituality (d930); political life and citizenship (d950)</p> <p><b>Sources of information:</b><br/> <input type="checkbox"/> Case history    <input type="checkbox"/> Patient reported questionnaire    <input type="checkbox"/> Clinical examination    <input type="checkbox"/> Technical investigation</p> <p><b>Description of the problem:</b></p>                                                                                    |                                                      |   |                          |                          |                          |                          |                          |                          |



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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| d920                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Recreation and leisure | P | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                        | C | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <p><b>Engaging in any form of play, recreational or leisure activity, such as informal or organized play and sports, programmes of physical fitness, relaxation, amusement or diversion, going to art galleries, museums, cinemas or theatres; engaging in crafts or hobbies, reading for enjoyment, playing musical instruments; sightseeing, tourism and travelling for pleasure.</b></p> <p>Inclusions: play, sports, arts and culture, crafts, hobbies and socializing</p> <p>Exclusions: riding animals for transportation (d480); remunerative and non-remunerative work (d850 and d855); religion and spirituality (d930); political life and citizenship (d950)</p> |                        |   |                          |                          |                          |                          |                          |                          |
| <p><b>Sources of information:</b></p> <p><input type="checkbox"/> Case history      <input type="checkbox"/> Patient reported questionnaire      <input type="checkbox"/> Clinical examination      <input type="checkbox"/> Technical investigation</p>                                                                                                                                                                                                                                                                                                                                                                                                                    |                        |   |                          |                          |                          |                          |                          |                          |
| <p><b>Description of the problem:</b></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                        |   |                          |                          |                          |                          |                          |                          |

| ENVIRONMENTAL FACTORS                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Complete facilitator     | Substantial facilitator  | Moderate facilitator     | Mild facilitator         | No barrier / facilitator | Mild barrier             | Moderate barrier         | Severe barrier           | Complete barrier         | Not specified            | Not applicable           |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Make up the physical, social and attitudinal environment in which people live and conduct their lives.                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| <b>How much of a facilitator or barrier does the person experience with respect to ...</b><br><br>You can also rate environmental factors as both a facilitator and barrier if applicable. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| e110                                                                                                                                                                                       | <b>Products or substances for personal consumption</b><br><br><b>Any natural or human-made object or substance gathered, processed or manufactured for ingestion.</b><br>Inclusions: food, drink and drugs<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e115                                                                                                                                                                                       | <b>Products and technology for personal use in daily living</b><br><br><b>Equipment, products and technologies used by people in daily activities, including those adapted or specially designed, located in, on or near the person using them.</b><br>Inclusions: general and assistive products and technology for personal use<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e120                                                                                                                                                                                       | <b>Products and technology for personal indoor and outdoor mobility and transportation</b><br><br><b>Equipment, products and technologies used by people in activities of moving inside and outside buildings, including those adapted or specially designed, located in, on or near the person using them.</b><br>Inclusions: general and assistive products and technology for personal indoor and outdoor mobility and transportation<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e125                                                                                                                                                                                       | <b>Products and technology for communication</b><br><br><b>Equipment, products and technologies used by people in activities of sending and receiving information, including those adapted or specially designed, located in, on or near the person using them.</b><br>Inclusions: general and assistive products and technology for communication<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e135                                                                                                                                                                                       | <b>Products and technology for employment</b><br><br><b>Equipment, products and technology used for employment to facilitate work activities.</b><br>Inclusion: general and assistive products and technology for employment<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e150                                                                                                                                                                                       | <b>Design, construction and building products and technology of buildings for public use</b><br><br><b>Products and technology that constitute an individual's indoor and outdoor human-made environment that is planned, designed and constructed for public use, including those adapted or specially designed.</b><br>Inclusions: design, construction and building products and technology of entrances and exits, facilities and routing<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| e155 | <b>Design, construction and building products and technology of buildings for private use</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <b>Products and technology that constitute an individual's indoor and outdoor human-made environment that is planned, designed and constructed for private use, including those adapted or specially designed.</b><br>Inclusions: design, construction and building products and technology of entrances and exits, facilities and routing<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                                                                                                                                                                     |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| e225 | <b>Climate</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <b>Meteorological features and events, such as the weather.</b><br>Inclusions: temperature, humidity, atmospheric pressure, precipitation, wind and seasonal variations<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| e310 | <b>Immediate family</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <b>Individuals related by birth, marriage or other relationship recognized by the culture as immediate family, such as spouses, partners, parents, siblings, children, foster parents, adoptive parents and grandparents.</b><br>Exclusions: extended family (e315); personal care providers and personal assistants (e340)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                                                                                                                                                                                    |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| e320 | <b>Friends</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <b>Individuals who are close and ongoing participants in relationships characterized by trust and mutual support.</b><br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| e340 | <b>Personal care providers and personal assistants</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <b>Individuals who provide services as required to support individuals in their daily activities and maintenance of performance at work, education or other life situation, provided either through public or private funds, or else on a voluntary basis, such as providers of support for home-making and maintenance, personal assistants, transport assistants, paid help, nannies and others who function as primary caregivers.</b><br>Exclusions: immediate family (e310); extended family (e315); friends (e320); general social support services (e5750); health professionals (e355)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b> |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| e355 | <b>Health professionals</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <b>All service providers working within the context of the health system, such as doctors, nurses, physiotherapists, occupational therapists, speech therapists, audiologists, orthotist-prosthetists, medical social workers.</b><br>Exclusion: other professionals (e360)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                                                                                                                                                                                                                                    |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| e360 | <b>Other professionals</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <b>All service providers working outside the health system, including social workers, lawyers, teachers, architects and designers.</b><br>Exclusion: health professionals (e355)<br><b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation<br><b>Description of the facilitator/barrier:</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |

|      |                                                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
|------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| e410 | Individual attitudes of immediate family members                                                                                                                                                                                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | General or specific opinions and beliefs of immediate family members about the person or about other matters (e.g. social, political and economic issues) that influence individual behaviour and actions.                                                        |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Sources of information:<br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Description of the facilitator/barrier:                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      |                                                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| e420 | Individual attitudes of friends                                                                                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | General or specific opinions and beliefs of friends about the person or about other matters (e.g. social, political and economic issues) that influence individual behaviour and actions.                                                                         |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Sources of information:<br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Description of the facilitator/barrier:                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      |                                                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| e425 | Individual attitudes of acquaintances, peers, colleagues, neighbours and community members                                                                                                                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | General or specific opinions and beliefs of acquaintances, peers, colleagues, neighbours and community members about the person or about other matters (e.g. social, political and economic issues) that influence individual behaviour and actions.              |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Sources of information:<br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Description of the facilitator/barrier:                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      |                                                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| e450 | Individual attitudes of health professionals                                                                                                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | General or specific opinions and beliefs of health professionals about the person or about other matters (e.g. social, political and economic issues) that influence individual behaviour and actions.                                                            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Sources of information:<br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Description of the facilitator/barrier:                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      |                                                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| e460 | Societal attitudes                                                                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | General or specific opinions and beliefs generally held by people of a culture, society, subcultural or other social group about other individuals or about other social, political and economic issues that influence group or individual behaviour and actions. |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Sources of information:<br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Description of the facilitator/barrier:                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      |                                                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| e540 | Transportation services, systems and policies                                                                                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | Services, systems and policies for enabling people or goods to move or be moved from one location to another.                                                                                                                                                     |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Sources of information:<br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Description of the facilitator/barrier:                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      |                                                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
| e570 | Social security services, systems and policies                                                                                                                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | Services, systems and policies aimed at providing income support to people who, because of age, poverty, unemployment, health condition or disability require public assistance that is funded either by general tax revenues or contributory schemes.            |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Exclusion: economic services, systems and policies (e565)                                                                                                                                                                                                         |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Sources of information:<br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | Description of the facilitator/barrier:                                                                                                                                                                                                                           |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |

|      |                                                                                                                                                                                                                                   | +4                       | +3                       | +2                       | +1                       | 0                        | 1                        | 2                        | 3                        | 4                        | 8                        | 9                        |
|------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| e580 | Health services, systems and policies                                                                                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|      | <b>Services, systems and policies for preventing and treating health problems, providing medical rehabilitation and promoting a healthy lifestyle.</b><br>Exclusion: general social support services, systems and policies (e575) |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | <b>Sources of information:</b><br><input type="checkbox"/> Case history <input type="checkbox"/> Patient reported questionnaire <input type="checkbox"/> Clinical examination <input type="checkbox"/> Technical investigation    |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
|      | <b>Description of the facilitator/barrier:</b>                                                                                                                                                                                    |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |