Level of Function Survey – mRS-9Q

1. Do you have any symptoms that are bothering you? (For example, trouble with reading or writing, trouble speaking, problems with vision, numbness, weakness, balance trouble, or problems with swallowing?)	YES ○	NO ○
2. Are you able to do the same work as before?	YES ○	NO ○
3. Are you able to keep up with your hobbies?	YES ○	NO ○
4. Have you maintained your ties to friends and family?	YES ○	NO ○
5. Do you need help making a simple meal, doing household chores, or balancing a checkbook?	YES ○	NO ○
6. Do you need help with shopping or traveling close to home?	YES ○	NO ○
7. Do you need another person to help you walk?	YES ○	NO ○
8. Do you need help with eating, going to the toilet, or bathing?	YES ○	NO ○
9. Do you stay in bed most of the day and need constant nursing care?	YES ○	NO ○