## 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 ○