

File No.:	Decision No.:
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Service No(s).:
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**Quality of Life (QOL) Questionnaire**

Family name:	Given name:	Date of Birth:
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Name of Physician:	Date of Examination:
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**This Quality of Life Questionnaire is used by the Department to determine the effect of your claimed/entitled condition on various aspects of your life, such as: preparing meals, doing housework, repairs, shopping, using transportation, employment, recreational and community activities, personal relationships with family, friends and acquaintances and enjoyment of family and/or social outings and family arrangements.**

**If you require assistance to complete this form, a departmental staff member or another individual of your choice (e.g. a family member) may assist you.**

**A QOL Questionnaire should be filled out for each separate and distinct condition.**

Indicate the claimed/entitled condition that impacts your QOL:

Select the activity that best describes the QOL effect from your claimed/entitled condition.

Activity	Yes with special aids or assistance			No
	Yes			
1. I can do my usual household chores (prepare meals, laundry, etc.).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
2. I can shop and/or do errands.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
3. I can drive a vehicle or use public transportation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
4. I am able to work in my regular occupation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> Retired
5. I can effectively participate in my usual and accustomed recreational and community activities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
6. I am able to maintain my usual day-to-day family responsibilities, including social outings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
7. I am able to maintain my personal/social relationships. (e.g. family, friends, colleagues, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
8. <b>(This question is optional. You do not have to answer.)</b> My sexual (intimate) relationships are maintained.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> N/A

If you have answered "No" to any of the above statements, please provide details:

**Contributing Conditions:**

Do you feel that the changes you have described in your lifestyle are entirely caused by your claimed condition(s) and/or entitled condition(s)?  Yes  No

Is there an impact from other non-entitled or non-claimed conditions?  Yes  No

Please explain:

The information you provide on this form is collected under the authority of the *Pension Act* or *Canadian Forces Members and Veterans Re-establishment and Compensation Act* for the purpose of assisting in the determination of the QOL rating which is added to the Medical Impairment rating to arrive at the Disability Assessment of a disability benefit. The information provided is protected from unauthorized disclosure by the *Privacy Act*. A copy of this completed form may be requested by writing to Access to Information and Privacy Coordinator's Office, Veterans Affairs Canada, P.O. Box 7700, Charlottetown, PE, CIA 8M9.

Client's signature	Today's date:
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