DIFFICULTY IN PERFORMING ACTIVITIES OF DAILY LIVING

PATIENT NAME: _____

Check each of the activities which you have difficulty performing and/or can perform only with pain. (There is no particular priority in the order presented.)

HOUSEWORK

_____ Doing laundry
_____ Making Beds
_____ Vacuuming
_____ Washing dishes
_____ Ironing
_____ Carrying groceries
_____ Caring for pets
_____ Cooking
_____ Other _____

YARDWORK

_____ Mowing lawn
_____ Shoveling snow
_____ Raking leaves
_____ Gardening

GENERAL

_____ Walking
_____ Standing
_____ Running
_____ Sitting
_____ Lifting children
_____ Bending
_____ Climbing stairs
_____ Reading
_____ Lying in bed
_____ Chewing
_____ Swimming
_____ Sports: _____

PERSONAL GROOMING

_____ Combing hair
_____ Shaving
_____ In / out bathtub
_____ Brushing teeth
_____ Other _____

TRAVEL

_____ Driving
_____ Riding (Passenger)

Minutes per day
Type of vehical
Auto _____
Train _____
Bus _____
Truck _____
Airplane _____

_____ Getting in and out of auto
_____ Playing piano
_____ Using typewriter/computer
_____ Kneeling
_____ Sexual Intercourse
_____ Exercising
_____ Sleeping
_____ Using Telephone
_____ Sitting in recliner

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose: _____

_____

_____

_____ _____

Patients Signature Date