

Activities of Daily Living/Symptoms/Medications

Patient Name: _____

File# _____

Date: _____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

	NO PAIN(0)			SOMEWHAT MODERATE PAIN(5)				DISABLING PAIN/SEVERE(10)			
	0	1	2	3	4	5	6	7	8	9	10
Bending	0	1	2	3	4	5	6	7	8	9	10
Carrying	0	1	2	3	4	5	6	7	8	9	10
Climbing	0	1	2	3	4	5	6	7	8	9	10
Concentrating	0	1	2	3	4	5	6	7	8	9	10
Dancing	0	1	2	3	4	5	6	7	8	9	10
Doing Chores	0	1	2	3	4	5	6	7	8	9	10
Doing Computer Work	0	1	2	3	4	5	6	7	8	9	10
Dressing	0	1	2	3	4	5	6	7	8	9	10
Driving	0	1	2	3	4	5	6	7	8	9	10
Gardening	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Performing Sexual Activities	0	1	2	3	4	5	6	7	8	9	10
Playing Sports	0	1	2	3	4	5	6	7	8	9	10
Pushing	0	1	2	3	4	5	6	7	8	9	10
Reading	0	1	2	3	4	5	6	7	8	9	10
Recreating	0	1	2	3	4	5	6	7	8	9	10
Rolling Over	0	1	2	3	4	5	6	7	8	9	10
Running	0	1	2	3	4	5	6	7	8	9	10
Shoveling	0	1	2	3	4	5	6	7	8	9	10
Sitting	0	1	2	3	4	5	6	7	8	9	10
Sitting to Standing	0	1	2	3	4	5	6	7	8	9	10
Sleeping	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Walking	0	1	2	3	4	5	6	7	8	9	10
Watching TV	0	1	2	3	4	5	6	7	8	9	10
Working	0	1	2	3	4	5	6	7	8	9	10

Please mark P for in the Past, C for Currently have and N for Never

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pregnant (Now) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Impotence/Sexual Dysfun. | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Jaw Pain, TMJ | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Heart Problem |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Tremors | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Pain w/Cough/Sneeze | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Menopausal Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Foot or Knee Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Menstrual Problem | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Sinus/Drainage Problem | <input type="checkbox"/> Depression | <input type="checkbox"/> PMS | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Back Curvature | <input type="checkbox"/> Swollen/Painful Joints | <input type="checkbox"/> Irritable | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Kidney Trouble |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Mood Changes | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Gall Bladder Trouble |
| <input type="checkbox"/> Numb/Tingling arms, hands, fingers | | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Liver Trouble |
| <input type="checkbox"/> Numb/Tingling legs, feet, toes | | <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Hepatitis (A,B,C) |

List Prescription & Non-Prescription drugs you take: _____
