

Activities of Daily Living/Symptoms/Medications

Date: _____

Patient Name: _____

File# _____

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:

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

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: _____
