

Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Date: \_\_\_\_\_

## Activities and Daily Living Assessment

Rate your current difficulties with the following activities, using a scale from 1-5. Write in the number that most appropriately corresponds to the difficulty level with each specific activity.

SECTION A		SECTION B	
<p><b>1 = "I can do it without any difficulty."</b>  <b>2 = "I can do it without much difficulty, despite some pain."</b>  <b>3 = "I manage to do it by myself, despite marked pain."</b>  <b>4 = "I manage to do it, despite the pain, but only if I have help."</b>  <b>5 = "I cannot do it at all, because of the pain."</b></p>		<p><b>1="This area is not affected by my condition."</b>  <b>2="This area is slightly affected by my condition."</b>  <b>3="This area is moderately affected by my condition."</b>  <b>4="My condition seriously limits my ability in this area."</b>  <b>5="My condition prevents me from using this ability."</b></p>	
<p><b><u>Self &amp; Personal Care</u></b></p> <p>_____ Bathing            _____ Showering            _____ Washing Hair            _____ Drying Hair            _____ Combing Hair            _____ Washing Face            _____ Brushing Teeth            _____ Making Bed            _____ Putting on Shirt            _____ Putting on Shoes            _____ Tying Shoes            _____ Putting on Pants            _____ Preparing Meals            _____ Eating            _____ Cleaning Dishes            _____ Taking Out Trash            _____ Doing Laundry            _____ Going to Toilet</p>	<p><b><u>Functional Activities</u></b></p> <p>_____ Carrying Small Objects            _____ Carrying Large Objects            _____ Carrying Brief Case            _____ Carrying Large Purse            _____ Lifting Weights off Floor            _____ Lifting Weights off Table            _____ Climbing Stairs            _____ Climbing Inclines            _____ Pushing While Seated            _____ Pushing while Standing            _____ Pulling while Seated            _____ Pulling while Standing            _____ Exercising Upper Body            _____ Exercising Lower Body            _____ Exercising Arms            _____ Exercising Legs</p>	<p><b><u>Communication</u></b></p> <p>_____ Concentration            _____ Hearing            _____ Listening            _____ Speaking            _____ Reading            _____ Writing            _____ Use Keyboard</p>	<p><b><u>Hand Functions</u></b></p> <p>_____ Grasping            _____ Holding            _____ Pinching            _____ Percussive Moves            _____ Sensory Discrimination</p>
<p><b><u>Physical Activities</u></b></p> <p>_____ Standing            _____ Sitting            _____ Reclining            _____ Standing(Long Periods)            _____ Walking            _____ Stooping            _____ Squatting            _____ Kneeling            _____ Reaching            _____ Bending Forward            _____ Sitting (Long Periods)            _____ Bending Back            _____ Bending Left            _____ Bending Right            _____ Twisting Left            _____ Twisting Right            _____ Leaning Forward            _____ Walking(Long Periods)            _____ Leaning Back            _____ Leaning Left            _____ Leaning Right            _____ Kneeling(Long Periods)</p>	<p><b><u>Social &amp; Recreational</u></b></p> <p>_____ Bowling            _____ Golfing            _____ Jogging            _____ Dancing            _____ Swimming            _____ Skiing            _____ Ice Skating            _____ Roller Skating            _____ Competitive Sports            _____ Hobbies            _____ Dating            _____ Dining Out</p>	<p><b><u>Senses</u></b></p> <p>_____ Seeing            _____ Hearing            _____ Sense Touch            _____ Sense of Taste            _____ Sense of Smell</p>	<p><b><u>Sleep and Sexual Function</u></b></p> <p>_____ Able to have a normal, restful night of sleep.            _____ Able to participate in desired sexual activity.</p>
		<p><b><u>Prior Similar Symptoms:</u></b></p> <p><input type="checkbox"/> I have NOT had prior symptoms similar to my current complaints.  <input type="checkbox"/> My current complaints DID exist before, but have not been bothering me.  <input type="checkbox"/> My current complaints ALREADY existed and were worsened.</p>	
		<p><b><u>Has your History Contributed to your current symptoms?</u></b></p> <p><input type="checkbox"/> My history HAS contributed to my current symptoms.  <input type="checkbox"/> My history HAS NOT contributed to my current symptoms.  <input type="checkbox"/> I'm NOT SURE if my history has contributed to my current symptoms.</p>	
		<p>My most recent prior similar symptoms (if applicable) occurred _____ <input type="checkbox"/> months ago / <input type="checkbox"/> years ago / Or on Date: ___/___/___.</p>	

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