

Name: _____

Date: _____

ACTIVITIES OF LIFE

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life: (Leave blank if the activity is not affected)

ACTIVITIES:	EFFECT:		
Carry Children/Groceries	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sit to Stand	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Climb Stairs	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Exercising	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Extended Computer Use	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Lifting (Children/Groceries)	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Read/Concentrate	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Getting Dressed	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Shaving/Brush Teeth	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sexual Activities	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sleep	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Yard work	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Walking	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Washing/Bathing	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Sweeping/Vacuuming	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Household Chores	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Reaching Overhead	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Bending	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Looking over shoulder	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform
Other: _____	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (limits)	<input type="checkbox"/> Unable to Perform

Details you want the doctor to know: _____

Please mark P for in the Past, C for Currently have, or leave blank if it does not apply to you

- | | | | | |
|---|---|--|---|---|
| <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) |

Patient signature: _____ **Today's Date:** __/__/__