

Activities of Daily Living

Office of James D. Olin, D.C.

Please check the box that most closely describes your degree of difficulty:

| Self Care | I can do without pain | I can do despite pain | I can do, but only with help | I cannot do at all because of the pain |
|-------------------------------|------------------------------|------------------------------|-------------------------------------|---|
| 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 | | | | |
| Physical Activities | I can do without pain | I can do despite pain | I can do, but only with help | I cannot do at all because of the pain |
| standing | | | | |
| sitting | | | | |
| reclining | | | | |
| standing for long periods | | | | |
| walking | | | | |
| stooping | | | | |
| squatting | | | | |
| kneeling | | | | |
| reaching | | | | |
| bending forward | | | | |
| sitting for long periods | | | | |
| bending backwards | | | | |
| bending left | | | | |
| bending right | | | | |
| twisting left | | | | |
| twisting right | | | | |
| leaning forward | | | | |
| leaning backwards | | | | |
| leaning left | | | | |
| leaning right | | | | |
| walking for long periods | | | | |
| kneeling for long periods | | | | |
| Functional Activities | I can do without pain | I can do despite pain | I can do, but only with help | I cannot do at all because of the pain |
| carrying small objects | | | | |
| carrying large objects | | | | |
| carrying brief case | | | | |
| carrying large purse | | | | |
| lifting weights off floor | | | | |
| lifting weights of table | | | | |
| climbing stairs | | | | |
| climbing inclines | | | | |
| pushing things while seated | | | | |
| pushing things while standing | | | | |
| pulling things while seated | | | | |
| pulling things while standing | | | | |

Patient's Name: _____

Date: _____

Activities of Daily Living

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| | I can do without pain | I can do despite pain | I can do, but only with help | I cannot do at all because of the pain |
|-----------------------|-----------------------|-----------------------|------------------------------|--|
| exercising upper body | | | | |
| exercising lower body | | | | |
| exercising arms | | | | |
| exercising legs | | | | |

Social/Recreational Activities Please select one of the following that most closely matches:

- I am enjoying a normal, active social life without pain restrictions.
- The presence of pain affects only the more energetic activities of my social life (bowling, golfing, sports, etc.).
- I participate in a normal social life, but pain is increased during most activities.
- Pain restricts all of my social activities; therefore, I do not go as often.
- I am restricted to social activities at home due to pain.
- Due to pain, I do not participate in any social activities.

| Traveling | I can do without pain | I can do despite pain | I can do, but only with help | I cannot do at all because of the pain |
|----------------------------------|-----------------------|-----------------------|------------------------------|--|
| driving a motor vehicle | | | | |
| driving for long periods of time | | | | |
| riding in a vehicle | | | | |
| riding on an airplane | | | | |
| riding for long periods | | | | |

Please check the box that most closely describes your ability to perform the following:

| Communication | Not affected | Affected | Seriously affected | Prevented |
|------------------|--------------|----------|--------------------|-----------|
| concentrating | | | | |
| hearing | | | | |
| listening | | | | |
| speaking | | | | |
| reading | | | | |
| writing | | | | |
| using a keyboard | | | | |

| Senses | Not affected | Affected | Seriously affected | Prevented |
|----------------|--------------|----------|--------------------|-----------|
| seeing | | | | |
| hearing | | | | |
| sense of touch | | | | |
| sense of taste | | | | |
| sense of smell | | | | |

| Hand Functions | Not affected | Affected | Seriously affected | Prevented |
|------------------------|--------------|----------|--------------------|-----------|
| grasping | | | | |
| holding | | | | |
| pinching | | | | |
| percussive movements | | | | |
| sensory discrimination | | | | |

| Sleep/Sexual Function | Not affected | Affected | Seriously affected | Prevented |
|--|--------------|----------|--------------------|-----------|
| normal, restful nights sleep | | | | |
| participate in desired sexual activity | | | | |

Please list any additional activities you may have difficulty performing:

Patient's Name: _____ **Date:** _____