Last Name ____________________ First Name ____________________ Acct. # __________

Please check off each of the activities which you have difficulty performing and/or can only perform with pain.

HOUSEWORK

___ Doing laundry
___ Making beds
___ Vacuuming
___ Washing dishes
___ Ironing
___ Carrying groceries
___ Caring for pets
___ Cooking
___ Other____________________

YARD WORK

___ Mowing the lawn
___ Shoveling
___ Raking leaves
___ Weeding / Gardening
___ Other ____________________

GENERAL

___ Walking
___ Standing
___ Running
___ Sitting
___ Bending
___ Kneeling
___ Climbing Stairs
___ Reading
___ Lying in bed
___ Sleeping
___ Sexual intercourse
___ Chewing
___ Child care (lifting)
___ Sports or Exercise: (Specify)
____
___ Playing musical instrument: (Specify) ______________
___ Using computer
___ Using the telephone

PERSONAL GROOMING

___ Combing / Brushing hair
___ Shaving
___ Getting in / out of the bathtub
___ Brushing teeth
___ Other____________________

TRAVEL

___ Driving auto / truck
___ Riding auto / truck
___ Getting in/out of automobile / truck

OTHER

Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose.

____
____
____
____

ADDITIONAL COMMENTS YOU MAY HAVE:

____
____
____
____

PATIENT'S SIGNATURE:

____

Date:______________