Activities of Employment, Daily Living and Recreation

Patient Name: ________________________ Acct #: ______________ Date: ________________

Current Complaints and/or Conditions: (List in order of severity)

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

Section 1 - How Current Complaints / Conditions Affect My Performance On-The-Job:

No Affect___ Mildly Painful (Can do)___ Moderately Painful (Limited)___ Severe (cannot work at all, even limited duty)___

Description of Current Work Duties: ____

I am currently working full time____ part time_______ hrs Currently working with a Limited Duty Release ______

I am working at full capacity_______ partial capacity____ There is no Limited Duty offered at my job __________

Use the following 1-4 scale to rate your current difficulties relative to your condition/accident/illness.
WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty with each of the various activities listed below. NOTE: Only mark the activities that are affected. No number means no difficulty.

1 - Mild Pain or Difficulty but able to perform
2 - Moderate Pain or Difficulty but able to perform
3 - Significant Pain or Difficulty, need help to perform
4 - Severe Pain or Difficulty, unable to perform

Section 2 - How Current Complaints / Conditions Affect My Performance of Daily Living Activities:

Self Care and Personal Hygiene

___ bathing / showering ___ brushing teeth ___ putting on pants ___ making the bed
___ washing / grooming hair ___ putting on makeup ___ putting on shoes / boots ___ putting on shirt / blouse / coat
___ washing face / shaving ___ feeding self ___ tying shoes / boots ___ going to the toilet

House and Home

___ care of children ___ household chores ___ shopping ___ taking out trash
___ care of family member(s) ___ preparing meals ___ vacuuming ___ gardening / weeding
___ care of pets ___ washing dishes ___ doing laundry ___ mowing / raking the lawn

Physical Activities

___ standing ___ standing for long periods ___ bending body forward ___ reaching forward ___looking up
___ walking ___ walking for long periods ___ bending body backward ___ reaching up ___looking down
___ sitting ___ sitting for long periods ___ bending body left / right ___ stooping / squatting ___balancing
___ reclining ___ rising from sitting ___ turning body left / right ___ exercising upper body ___kneeling
___ lying down ___ rising from lying down ___ turning head left / right ___ exercising lower body ___crawling

Functional Activities

___ carrying small objects ___ lifting objects off floor ___ going up stairs/inclines ___ pushing / pulling while seated
___ carrying large objects ___ lifting objects off table ___ climbing a ladder ___ pushing / pulling while standing
___ carrying a briefcase/purse ___ lifting items out of car ___ using tools / utensils ___ other:____________________

Section 3 - How Current Complaints / Conditions Affect My Performance of Social and Recreational Activities:

___ running / jogging ___ swimming ___ golfing ___dancing ___ skiing ___ snowboarding
___ bicycling ___ competitive sports ___ dating ___dining out ___ other:____________________

Difficulties with Traveling

___ driving a car or truck ___ driving for long periods of time ___ bus or train travel ___ motorcycling
___ riding as a passenger ___ riding as a passenger for long periods ___ plane travel ___ other:________________

Use this 1-4 scale for the following activities:

1 - This activity is slightly affected by my condition
2 - This activity is moderately affected by my condition
3 - This activity is severely affected by my condition
4 - I cannot perform this activity due to my condition

___ concentrating / focusing ___ speaking / singing ___ using computer keyboard / mouse
___ thinking clearly ___ chewing ___ being able to participate in desired sexual activity
___ listening ___ vision (focus, comfort) ___ being able to have a normal, restful nights sleep
___ reading / studying ___ sense of touch
___ writing ___ sense of taste
___ doing paperwork ___ sense of smell

My usual sleeping position is:

☐ on my back ☐ on my stomach
☐ on my side ☐ changes throughout night

Other Activities or Functions Not Mentioned Above: ____