

Activities of Daily Living

To properly assess your condition, we must understand how much your health problems have affected your ability to manage everyday activities. For each item below, please circle the number which most closely describes your condition right now.

- | | | | | | |
|--|---------|-----------|---------------|-------------|---------------------|
| 1. Static Sitting | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 2. Sleeping | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 3. Personal Care
(washing, Dressing, etc.) | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 4. Travel
(driving, etc.) | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 5. Work | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 6. Recreation | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 7. Household Chores
(Vacuuming, Cleaning, Etc.) | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 8. Lifting | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 9. Walking | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |
| 10. Standing | 0 | 1 | 2 | 3 | 4 |
| | No pain | Mild pain | Moderate pain | Severe pain | Worst possible pain |

Patient's Signature: _____ Today's Date: _____