



Patient Name _____

ACTIVITIES OF DAILY LIVING

Please mark all activities you experience trouble in performing or completing by yourself:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Baking | <input type="checkbox"/> Bending | <input type="checkbox"/> Buttoning clothes | Exercising |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Bending Arm | <input type="checkbox"/> Doing Things on Time | <input type="checkbox"/> Elliptical |
| <input type="checkbox"/> Care of Others | <input type="checkbox"/> Bending Leg | <input type="checkbox"/> Playing with grandchildren | <input type="checkbox"/> Jogging |
| <input type="checkbox"/> Care of Pets | <input type="checkbox"/> Carrying objects | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Pilates |
| <input type="checkbox"/> Caring of children | <input type="checkbox"/> Climbing stairs | <input type="checkbox"/> Sitting to standing | <input type="checkbox"/> Row machine |
| <input type="checkbox"/> Cleaning | <input type="checkbox"/> Crouching/Squatting | <input type="checkbox"/> Standing to sitting | <input type="checkbox"/> Stair climber |
| <input type="checkbox"/> Concentrating | <input type="checkbox"/> General Mobility | <input type="checkbox"/> Using the computer | <input type="checkbox"/> Stretching |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Head movement down | <input type="checkbox"/> Using the phone | <input type="checkbox"/> Treadmill |
| <input type="checkbox"/> Doctor's office | <input type="checkbox"/> Head movement up | | <input type="checkbox"/> Water aerobics |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Holding on to objects | | <input type="checkbox"/> Weight lifting |
| <input type="checkbox"/> Driving | <input type="checkbox"/> Keeping balance | | <input type="checkbox"/> Yoga |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Leaning | Hobbies | |
| <input type="checkbox"/> Financial Management | <input type="checkbox"/> Lifting | <input type="checkbox"/> Coloring | |
| <input type="checkbox"/> Getting places | <input type="checkbox"/> Lying down | <input type="checkbox"/> Crocheting | Sports |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Moving joint(s) | <input type="checkbox"/> Dancing | <input type="checkbox"/> Baseball |
| <input type="checkbox"/> Housework | <input type="checkbox"/> Pulling with feet | <input type="checkbox"/> Fishing | <input type="checkbox"/> Basketball |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Pulling with hands | <input type="checkbox"/> Gardening | <input type="checkbox"/> Bike Riding |
| <input type="checkbox"/> Making decisions | <input type="checkbox"/> Pushing with feet | <input type="checkbox"/> Knitting | <input type="checkbox"/> Bowling |
| <input type="checkbox"/> Mowing | <input type="checkbox"/> Pushing with hands | <input type="checkbox"/> Painting | <input type="checkbox"/> Canoeing |
| <input type="checkbox"/> Personal hygiene/grooming | <input type="checkbox"/> Reaching down | <input type="checkbox"/> Playing musical instrument | <input type="checkbox"/> Football |
| <input type="checkbox"/> Seeing | <input type="checkbox"/> Reaching up | <input type="checkbox"/> Playing piano | <input type="checkbox"/> Golf |
| <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Reaching out | <input type="checkbox"/> Reading | <input type="checkbox"/> Hiking |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Sitting | <input type="checkbox"/> Sewing | <input type="checkbox"/> Horseback Riding |
| <input type="checkbox"/> Speaking | <input type="checkbox"/> Standing | <input type="checkbox"/> Woodworking | <input type="checkbox"/> Ice Skating |
| <input type="checkbox"/> Watching TV | <input type="checkbox"/> Turning | | <input type="checkbox"/> Kayaking |
| <input type="checkbox"/> Working | <input type="checkbox"/> Twisting | | <input type="checkbox"/> Racket Ball |
| <input type="checkbox"/> Yard Work | <input type="checkbox"/> Walking | | |

List any other activity you have been able to do that you are no longer able to do:

Percentage of difficulty: 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%