NAME:
DATE OF INJURY:
TODAY'S DATE:

ACTIVITIES OF DAILY LIVING

Check each of the activities which you have difficulty performing ***today***. Indicate the current "pain" level from 1 (annoyance) to 10 (excruciating unbearable pain).

Work: 1-10

______ driving to/from work
______ sitting at a desk
______ working on the computer
______ walking around at work
______ standing at work
______ carrying material or lifting
______ running special errands
______ using the telephone
______ working outside
______ working in a warehouse
______ driving equipment
______ using tools

Housework: 1-10

______ doing laundry
______ making beds
______ vacuuming
______ washing dishes
______ ironing
______ carrying groceries
______ caring for children
______ cooking
______ caring for pets
______ outdoor chores
______ other: ________________

Personal Grooming: 1-10

______ grooming hair
______ shaving
______ brushing teeth
______ getting dressed
______ putting shoes on
______ taking a shower