Patient Name:____________________ DOB: _______________ Today's Date: _____-_____-_____

Daily Activities: Effects of Current conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life: 0-No pain, 10-worst pain imaginable

Activity											
Bending	0	1	2	3	4	5	6	7	8	9	10
Concentrating	0	1	2	3	4	5	6	7	8	9	10
Doing computer work	0	1	2	3	4	5	6	7	8	9	10
Gardening	0	1	2	3	4	5	6	7	8	9	10
Playing Sports	0	1	2	3	4	5	6	7	8	9	10
Recreation Activities	0	1	2	3	4	5	6	7	8	9	10
Shoveling	0	1	2	3	4	5	6	7	8	9	10
Sleeping	0	1	2	3	4	5	6	7	8	9	10
Watching TV	0	1	2	3	4	5	6	7	8	9	10
Carrying	0	1	2	3	4	5	6	7	8	9	10
Dancing	0	1	2	3	4	5	6	7	8	9	10
Dressing	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Pushing	0	1	2	3	4	5	6	7	8	9	10
Rolling Over	0	1	2	3	4	5	6	7	8	9	10
Sitting	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Working	0	1	2	3	4	5	6	7	8	9	10
Climbing	0	1	2	3	4	5	6	7	8	9	10
Doing Chores	0	1	2	3	4	5	6	7	8	9	10
Driving	0	1	2	3	4	5	6	7	8	9	10
Performing Sexual Activity	0	1	2	3	4	5	6	7	8	9	10
Reading	0	1	2	3	4	5	6	7	8	9	10
Running	0	1	2	3	4	5	6	7	8	9	10
Sitting to Standing	0	1	2	3	4	5	6	7	8	9	10
Walking	0	1	2	3	4	5	6	7	8	9	10

Patient Signature ____ Date ___-___-___

Doctor's Signiture____ Date ___-___-___