Specialized Therapy Services

890 Elm Grove Rd., BLDG 1-1,
Elm Grove, WI 53122
Phone: 414-778-1341
Fax: 262-794-3888

ACTIVITIES OF DAILY LIVING - page 1 of 2

PATIENT NAME: _____

Rate yourself (0-10) using the following pain scale on the activities listed below.

0. Able to perform task without pain
1. Able to perform task with minimal pain
2. Able to perform task with moderate pain
3. Able to perform task with significant pain
4. Able to perform task with severe pain
5. Difficulty performing task with minimal pain
6. Difficulty performing task with moderate pain
7. Difficulty performing task with significant pain
8. Difficulty performing task with severe pain
9. Unable to perform task because of pain
10. Restricted from activity per doctor
NA. Normally do not perform task

	Before Auto or Work injury	Current Date
GROOMING & DRESSING		
Get in and out of the tub or shower.		
Wash, blow dry, or curl hair.		
Reach to put on socks, shoes, hose, or pants.		
Reach overhead to put on shirt, sweater, or coat.		
Sub-total:	_____	_____
MOBILITY		
Walk up and down a flight of stairs.		
Get in and out of a car.		
Ride in a car for 20 minutes or more.		
Sub-total:	_____	_____
HOMEMAKING		
Reach for items out of the top cupboard.		
Reach for items in the lower cupboard.		
Bending or stooping to clean or scrub floors, walls or bathroom.		
Use the vacuum cleaner.		
Folding or ironing clothes		
Carry the laundry basket.		
Get the clothes out of the washer and dryer.		
Sub-total:	_____	_____
ERRANDS		
Carry the grocery or shopping bags.		
Stand in line at the bank or grocery store.		
Walking in the grocery store or shopping mall (20 minutes or more)		
Sub-total:	_____	_____
CHILD CARE (if applicable)		
Pick up and carry your child. (My child weighs _____ pounds)		
Lift your child in and out of the car.		
Sub-total:	_____	_____
AUTOMOBILE		
Routine maintenance on the car (includes oil changes/tune ups)		
Wash and vacuum the car.		
Sub-total:	_____	_____
RECREATION/LEISURE		
Enjoy the activities you used to. (Activities include _____)		
Exercise for fun.		
Sub-total:	_____	_____
GRAND TOTAL:		

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ACTIVITIES OF DAILY LIVING - Page 2 of 2

Patient Name: _____

TOLERANCE CHART

Place an "X" in the box that best describes the amount of time you can perform each activity before pain either limits the activity or causes you to modify that activity.

Date:

	Avoid activity	0-15 min	30 min	45 min	1 hr	2 hrs	3 hrs	4 hrs	5 hrs	6 hrs	7 hrs	8 + hrs / no limitations	Pain Location
ability to sit													
ability to stand													
ability to walk													
ability to sleep													

PAIN LEVEL CHART

For your initial evaluation reflect on your pain for the past 30 days. For your re-evaluation reflect on your pain for the past 24 hours. The pain scale is 0-10 with 0 = no pain and 10 = the worst pain.

	Description (tight, sore, sharp, stabbing, shooting, tingly, numb, tender, ache, throbbing)	**Intensity: 0-10** (none) 0 - 10 (severe) Worst	Best	**Frequency** **D** (Daily) **O** (Occasional) **R** (Rare)
Head				
Neck				
Chest				
Mid Back				
Lumbar				
Groin				
Buttocks				
Arms				
Right				
Left				
Legs				
Right				
Left				

ADDITIONAL COMMENTS: _____

_____

_____

_____