ACTIVITIES OF DAILY LIVING

Do you have stairs to climb? ( ) yes ( ) no If yes, how many ___________________________________
How many people in household?_____________Relationship and age of each_____________________
Who does most of the housework?________ Who does most of the shopping?___________________
On the scale below, circle number which best describes your situation: Most of the time I function…..

1	2	3	4	5
Very Poorly	Poorly	Ok	Well	Great

Because of Health Problems, do you have difficulty?
(Please check appropriate box for each question)

	Usually	Sometimes	No
Using you hands to grasp small objects? (buttons, toothbrush, pencil, etc)	☐	☐	☐
Walking ?………………………………………………………………	☐	☐	☐
Climbing stairs?..	☐	☐	☐
Descending stairs?..	☐	☐	☐
Sitting down?..	☐	☐	☐
Getting up from chair?..	☐	☐	☐
Touching your feet while seated?...	☐	☐	☐
Reaching behind your back?...	☐	☐	☐
Reaching behind your head?..	☐	☐	☐
Dressing yourself?..	☐	☐	☐
Going to sleep?...	☐	☐	☐
Staying asleep due to pain?...	☐	☐	☐
Obtaining restful sleep?...	☐	☐	☐
Bathing?..	☐	☐	☐
Eating?..	☐	☐	☐
Working?...	☐	☐	☐
Getting along with family members?...	☐	☐	☐
Engaging in leisure time activities?...	☐	☐	☐
Do you have trouble with morning stiffness?..	☐	☐	☐
Do you use a cane, walker or a wheelchair?...	☐	☐	☐

What is the hardest thing for you to do?____

Do you receive disability?... yes	( )	No	( )
Are you applying for disability?.. yes	( )	No	( )

Patient
Name____________________________Date___________________Physican____________________

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