SYMPTOMS and ACTIVITIES OF DAILY LIVING

Patient _____ Date _____

For each category of daily living listed, PLEASE INDICATE BY NUMBER in the space at right - how much your pain is preventing you from doing the activities or how much you have to modify the activities in each category. Indicate the overall impact of pain in your life, not just when the pain is at its worst.

0 = no disability at all, 10 = all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

0 1 2 3 4 5 6 7 8 9 10

Completely **able** to function — Totally **unable** to function

0 - 10 ☐

1. **FAMILY / HOME RESPONSIBILIES**: activities related to the home or family, including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) _____

2. **RECREATION**: hobbies, sports, and other similar leisure time activities. _____

3. **SOCIAL ACIVITY**: activities which involve participation with friends and acquaintances other than family members, including parties, theater, concerts, dining out, and other social functions. _____

4. **OCCUPATION**: activities that are a part of or directly related to one's job, including nonpaying jobs as well, such as that of a homemaker or volunteer worker. _____

5. **SELF CARE**: activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) _____

6. **LIFE SUPPORT ACTIVITY**: basic life supporting behaviors such as eating, sleeping, and breathing. _____

Circle below your average intensity or severity of pain / symptoms

Pain **INTENSITY**	**None**	**MILD** Discomfort/Ache/Stiff			**MODERATE** Hurts/Sore/Bearable				**SEVERE** Intense Pain		
Headaches	0	1	2	3	4	5	6	7	8	9	10
Neck pain / Soreness	0	1	2	3	4	5	6	7	8	9	10
Arm / Hand Symptoms	0	1	2	3	4	5	6	7	8	9	10
Mid Back Pain	0	1	2	3	4	5	6	7	8	9	10
Lower Back Pain	0	1	2	3	4	5	6	7	8	9	10
Leg / Foot Symptoms	0	1	2	3	4	5	6	7	8	9	10

Circle below the average percentage of time you have pain / symptoms

Pain **FREQUENCY**	**None**	**OCCASIONAL**		**INTERMITTENT**			**FREQUENT**			**CONSTANT**	
Headaches	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Neck pain / Soreness	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Arm / Hand Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Mid Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Lower Back Pain	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Leg / Foot Symptoms	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%