Optimal Wellness Chiropractic Center

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty.

Only fill in AREAS AFFECTED with a:
1 = "I can do it without any difficulty".
2 = "I can do it without much difficulty, despite some pain".
3 = "I manage to do it by myself, despite marked pain".
4 = "I manage to do it, despite the pain, but only if I have help".
5 = "I cannot do it all, because of the pain".

Difficulties with **Self Care and Personal Hygiene Activities** (Only fill in area affected)

_____ Bathing	_____ Drying hair	_____ Brushing teeth	_____ Putting on shoes	_____ Preparing meals
_____ Showering	_____ Combing hair	_____ Making bed	_____ Tying shoes	_____ Eating
_____ Washing hair	_____ Washing face	_____ Putting on shirt	_____ Putting on pants	_____ Cleaning dishes
_____ Going to toilet	_____ Taking out trash	_____ Doing laundry		

Difficulties with **Physical Activities** (Only fill in areas affected)

_____ Standing	_____ Stooping	_____ Bending back	_____ Leaning forward
_____ Sitting	_____ Squatting	_____ Bending left	_____ Leaning back
_____ Reclining	_____ Kneeling	_____ Bending right	_____ Leaning left
_____ Standing for long periods	_____ Reaching	_____ Walking for long periods	_____ Leaning right
_____ Kneeling for long periods	_____ Bending forward	_____ Twisting left	
_____ Walking	_____ Sitting for long periods	_____ Twisting right	

Difficulties with **Functional Activities** (Only fill in areas affected)

_____ Carrying small objects	_____ Lifting weights off table	_____ Pulling things while seated
_____ Carrying large objects	_____ Climbing stairs	_____ Pulling things while standing
_____ Carrying brief case	_____ Climbing inclines	_____ Exercising lower body
_____ Carrying large purse	_____ Exercising upper body	_____ Exercising arms
_____ Exercising legs	_____ Pushing things while seated	
_____ Lifting weights off floor	_____ Pushing things while standing	

Difficulties with **Social and Recreational Activities** (Only fill in areas affected)

_____ Bowling	_____ Dancing	_____ Ice skating
_____ Golfing	_____ Dining out	_____ Roller skating
_____ Hobbies	_____ Swimming	_____ Competitive sports
_____ Jogging	_____ Skiing	_____ Dating

Difficulties with **Traveling** (Only fill in areas affected)

_____ Driving motor vehicle	_____ Riding as a passenger in a motor vehicle
_____ Driving for long periods of time	_____ Riding as a passenger on an airplane
_____ Riding as a passenger for long periods	_____ Riding as a passenger on a train

Please Sign Name on Each Page _____ Date _____

Activities of Daily Living Assessment

Use the following 1 to 5 scale to describe the difficulties below (Only fill in AREAS AFFECTED)

1 = "This area is not affected by my condition".
2 = "This area is slightly affected by my condition".
3 = "My condition moderately restricts my ability in this area".
4 = "My condition seriously limits my ability in this area".
5 = "My condition prevents me from using this ability".

Difficulties with Different Forms of **Communication** (Only fill in areas affected)

_____ Concentrating _____ Speaking _____ Writing
_____ Hearing _____ Reading _____ Using a keyboard
_____ Listening

Difficulties with the **Senses** (Only fill in areas affected)

_____ Seeing _____ Hearing _____ Sense of touch _____ Sense of taste _____ Sense of smell

Difficulties with **Hand Functions** (Only fill in areas affected)

_____ Grasping _____ Holding _____ Pinching _____ Percussive movements _____ Sensory discrimination

Difficulties with **Sleep and Sexual Function** (Only fill in areas affected)

_____ Being able to have normal restful night's sleep _____ Being able to participate in desired sexual activity

Please write in below any other daily activities you are current having difficulties with due to your accident:

Prior Symptom History

Prior Similar Symptoms

- ☐ I have NOT had prior symptoms similar to my current complaints.
- ☐ My current complaints DID exist before, but had not been bothering me.
- ☐ My current complaints ALREADY existed and were worsened.

My most recent prior similar symptoms (if applicable) occurred:
_____ months ago/_____ years ago, OR on Date: _____

Has your History Contributed to your Current Symptoms?

- ☐ My history HAS contributed to my current symptoms.
- ☐ My history HAS NOT contributed to my current symptoms.
- ☐ I'm NOT SURE if my history has contributed to my current symptoms.

Please write in below any other symptoms or problems that you had BEFORE the accident that were not covered above:

Thank you for your time and thoroughness in filling out these forms. It will assist us in meeting your health care needs.

Please Sign Name on Each Page _____ Date _____

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