

CHART NO.

DOB:

Pioneer Spine and Sports Physicians

NAME:

ACTIVITIES OF DAILY FUNCTION

DATE:

DATE

NAME

_____/_____/_____
MONTH DAY YEAR

LAST FIRST MIDDLE INITIAL

Have you at times felt that decisions about you were made without your input or without sufficient information?

This form has been designed to gather that information to assist us in learning more about you and your specific problem areas and capability levels. Please fill out completely, making any changes you feel would better describe you own situation.

	<u>I CAN DO</u>				<u>I CAN DO</u>		
	WITHOUT/ SOME	WITH / SOME	I CANNOT DO AT ALL		WITHOUT/ SOME	WITH / SOME	I CANNOT DO AT ALL
1. GETTING UP FROM LYING DOWN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	17. DRESSING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. SITTING TO WATCH A TV SHOW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	18. OPENING JARS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. PUTTING ON SHOES OR BOOTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	19. TURNING ON AN OVEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CLIMBING STAIRS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	20. TURNING A DOOR KNOB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. CLIMBING LADDERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21. USING A SHOVEL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. DUSTING FURNITURE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	22. USING A LAWN RAKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. VACUUMING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	23. USING A LAWN MOWER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. SWEEPING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	24. USING A HAMMER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. WIPING UP SPILLS ON FLOORS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	25. TURNING A SCREWDRIVER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. PUTTING AWAY DISHES IN CUPBOARDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	26. CROCHETING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. PUTTING AWAY TOOLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	27. TAKING OUT GARBAGE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. WASHING DISHES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	28. GOING GROCERY SHOPPING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. COMBING HAIR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	29. DOING THE LAUNDRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. MAKING THE BED	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30. HOBBIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. HOLDING A BABY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31. RECREATIONAL ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. DRIVING THE CAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32. GARDENING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Each of us can be affected differently by the same thing. A song, picture, or a person may affect you differently than it would another. An injury may have that same diverse characteristic. Please check those statements that describe how your injury has affected you.

- | | |
|---|--|
| <input type="checkbox"/> 1. My injury has not affected any changes in me. | <input type="checkbox"/> 10. I cannot pick up small objects. |
| <input type="checkbox"/> 2. I wish I were better but my life is about the same as before. | <input type="checkbox"/> 11. I have frequent headaches. |
| <input type="checkbox"/> 3. I forget things more easily. | <input type="checkbox"/> 12. I have pain going down my leg (s). |
| <input type="checkbox"/> 4. As the weather changes, so does my pain. | <input type="checkbox"/> 13. I feel like my legs want to buckle. |
| <input type="checkbox"/> 5. I get angry more often. | <input type="checkbox"/> 14. I am frustrated with my situation. |
| <input type="checkbox"/> 6. I wake up often during the night. | <input type="checkbox"/> 15. I have visual problems. |
| <input type="checkbox"/> 7. I drop things frequently. | <input type="checkbox"/> 16. I have hearing changes. |
| <input type="checkbox"/> 8. There is tingling and/or trembling in my fingers. | <input type="checkbox"/> 17. I have allergies. |
| <input type="checkbox"/> 9. I have aching in my arm(s). | <input type="checkbox"/> 18. I want to cry often. |

These are generally:

1. Getting worse in the last _____ months. 2. Getting better in the last _____ months. 3. Staying about the same.

C. Check those you can pick up easily and hold onto while using.

- | | | |
|--|---|---|
| <input type="checkbox"/> 1. A dime | <input type="checkbox"/> 6. Pliers | <input type="checkbox"/> 11. An electric sander |
| <input type="checkbox"/> 2. A pen or pencil | <input type="checkbox"/> 7. A paint brush | <input type="checkbox"/> 12. An electric drill |
| <input type="checkbox"/> 3. A coffee cup | <input type="checkbox"/> 8. A hammer | <input type="checkbox"/> 13. A shovel |
| <input type="checkbox"/> 4. A telephone receiver | <input type="checkbox"/> 9. Hedge trimming sheers | <input type="checkbox"/> 14. A sledge hammer |
| <input type="checkbox"/> 5. A screwdriver | <input type="checkbox"/> 10. A hacksaw | <input type="checkbox"/> 15. A soldering iron |

II. SITTING, STANDING, AND WALKING

	0-20 minutes	20-40 minutes	40-60 minutes	1 to 2 hours	Over 2 hours
A. I can usually sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. I can usually stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. I can usually walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Please check as many of the following examples below that describe your present walking ability.

I can walk:

- | | |
|--|---|
| <input type="checkbox"/> 1. As well and as far as before | <input type="checkbox"/> 4. About one mile. |
| <input type="checkbox"/> 2. Distance of less than one block | <input type="checkbox"/> 5. I prefer to walk on soft surfaces. |
| <input type="checkbox"/> 3. Several blocks on pavement or in shopping centers. | <input type="checkbox"/> 6. I walk regularly. My doctor has recommended it. |

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III. LIFTING ABILITIES

A. Please check what you think you are able to lift:

- | | | |
|--|---|--|
| <input type="checkbox"/> 1. As much as I used to | <input type="checkbox"/> 4. Up to 20 pounds | <input type="checkbox"/> 7. Up to 50 pounds |
| <input type="checkbox"/> 2. Less than 5 pounds | <input type="checkbox"/> 5. Up to 30 pounds | <input type="checkbox"/> 8. 50 to 100 pounds |
| <input type="checkbox"/> 3. 5 to 10 pounds | <input type="checkbox"/> 6. Up to 40 pounds | <input type="checkbox"/> 9. Over 100 pounds |

B. My doctor has given me a weight restriction of _____ Pounds.

B. When I pick up something from the floor, I:

- | | |
|---|--|
| <input type="checkbox"/> 1. Bend at the knees | <input type="checkbox"/> 4. Keep feet apart |
| <input type="checkbox"/> 2. Bend at the waist | <input type="checkbox"/> 5. Other (describe) _____ |
| <input type="checkbox"/> 3. Squat | _____ |

IV. PAIN AND MOVEMENT

A. Please check if it is painful or difficult to move these body parts:

- | | | |
|------------------------------------|----------------------------------|---------------------------------|
| <input type="checkbox"/> Head | <input type="checkbox"/> Hands | <input type="checkbox"/> Knees |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Fingers | <input type="checkbox"/> Ankles |
| <input type="checkbox"/> Shoulders | <input type="checkbox"/> Back | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Arms | <input type="checkbox"/> Hips | <input type="checkbox"/> Toes |
| <input type="checkbox"/> Wrists | <input type="checkbox"/> Legs | |

B. My pain: 1. Is constant 2. Comes and goes depending on activity 3. Goes away with rest

C. On a scale of 1 to 10 (1= no pain and 10= maximal pain)
My pain generally ranges from _____ To _____

D. Check those statements that apply to you:

- 1. I am comfortable most of the time.
- 2. I take no pain medication at this time.
- 3. I must take medication to lower the level of pain.
- 4. My doctor has given me medication but I don't take it.
- 5. My doctor has given me medication and I take it as prescribed.
- 6. My doctor has given me medication, but I feel that I need more.
- 7. I feel that I need some kind of pain medication.

V. PRESENT LEVEL

A. Please check what you think describes your capability:

	Light Work	Moderate Work	Heavy Work
1. I have some pain, but I can do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My doctor has told me to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I think I can only do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. My doctor has told me not to work, but I think I can do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. IMPROVEMENT

A. Check the things that you feel would help you get better. I should:

- | | |
|---|--|
| <input type="checkbox"/> 1. Be in conditioning program. | <input type="checkbox"/> 5. Get more rehabilitation. |
| <input type="checkbox"/> 2. Exercise regularly. | <input type="checkbox"/> 6. Be admitted to the hospital for surgery. |
| <input type="checkbox"/> 3. Have more diagnostic tests. | <input type="checkbox"/> 7. Stop present treatment. |
| <input type="checkbox"/> 4. Try a different doctor. | <input type="checkbox"/> 8. Other (describe) _____ |

VII. TAKE A FEW MOMENTS AND DESCRIBE YOUR FUTURE VOCATIONAL GOALS:

VIII. TAKE A FEW MOMENTS AND DESCRIBE YOUR EXPECTATIONS MEDICALLY:

IX. PLEASE IDENTIFY ANYTHING YOU FEEL YOUR ASSESSMENT SPECIALIST SHOULD KNOW PRIOR TO BEGINNING THE ASSESSMENT THAT WAS NOT COVERED IN THIS QUESTIONNAIRE:

PATIENT SIGNATURE