

# ACTIVITIES OF DAILY LIVING

KAISER CHIROPRACTIC, S.C.

Patient Name: \_\_\_\_\_ File#: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please indicate any activity that you have discomfort **OR** difficulty doing at any time. Then, fill in the amount of time it takes before it affects you. **See the example below.**

If an ACTIVITY "does not apply" to you, please circle N/A.

DOES NOT APPLY	DO YOU HAVE <u>DISCOMFORT OR DIFFICULTY</u> :	AFTER HOW LONG?
N/A	<b>EXAMPLE:</b> Driving <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<u>30</u> min <u>      </u> hrs
N/A	Sitting/Driving <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Standing <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Walking <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Working <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Lying down <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Dress/Groom <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Computer <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Cook/Housework <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Garden/Yard Work <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Sports/Recreation <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> min <u>      </u> hrs
N/A	Does the pain wake you at night? <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> /day or <u>      </u> /wk
N/A	Do you get headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO	<u>      </u> /wk or <u>      </u> /mth

OFFICE USE ONLY		
C = CERVICAL / T = THORACIC / L = LUMBAR / O = OTHER		
ACTIVITIES OF DAILY LIVING	SHORT TERM GOALS	LONG TERM GOALS
SITTING/DRIVING: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
STANDING: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
WALKING: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
WORKING: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
LYING DOWN: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
DRESS/GROOM: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
COMPUTER: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
COOK/HOUSEWORK: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
GARDEN/YARD WORK: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
SPORTS/RECREATION: C T L O	<u>      </u> min <u>      </u> hr	<u>      </u> min <u>      </u> hr
FREQUENCY OF DISTURBED SLEEP: C T L O	<u>      </u> day <u>      </u> wk <u>      </u> month	<u>      </u> day <u>      </u> wk <u>      </u> month
FREQUENCY OF HEADACHES: C T L O	<u>      </u> day <u>      </u> wk <u>      </u> month	<u>      </u> day <u>      </u> wk <u>      </u> month

Please list the activities that are most important for you to see improvement.  Please list the most important first.  (for example: golf, work out, hold kids/grandkids, run, walk).	1	
	2	
	3	