Activities of Daily Living

Outcome Assessment Tool

Name:____ Date:________________

Areas of Pain and/or Dysfunction (Please list):____

*(If you have more than one area of pain and/ or dysfunction **ABBREVIATE** for each number on the scale of 0-10. Ex. N=Neck H=Hip LB=Low Back, etc. **ABOVE THE NUMBER**. If you have any questions please ask us.)*

	0	2	4	6	8	10
1. Pain Intensity	NO PAIN	INTERMITTENT PAIN	MILD PAIN	MODERATE PAIN	SEVERE PAIN	WORST POSSIBLE PAIN
2. Sleeping	PERFECT SLEEP	INTERMITTENTLY DISTURBED	MILDLY DISTURBED	MODERATELY DISTURBED	GREATLY DISTURBED	TOTALLY DISTURBED
3. Personal Care (washing, dressing, etc)	NO PAIN NO RESTRICTIONS	INTERMITTENT PAIN SOME RESTRICTION	MILD PAIN NEED TO GO SLOW	MODERATE PAIN NEED HELP	STRONG PAIN NEED HELP	SEVERE PAIN NEED 100% HELP
4. Travel (driving, etc)	NO PAIN ON LONG TRIPS	INTERMITTENT PAIN ON LONGTRIPS	MILD PAIN ON LONG TRIPS	MODERATE PAIN ON LONG TRIPS	MODERATE PAIN ON SHORT TRIPS	SEVERE PAIN ON SHORT TRIPS
5. Work	CAN DO USUAL WORK + EXTRA	CAN DO USUAL WORK, NO EXTRA	CAN DO 75% OF USUAL WORK	CAN DO 50% OF USUAL WORK	CAN DO 25% OF USUAL WORK	CANNOT WORK
6. Recreation	CAN DO ALL ACTIVITIES	CAN DO MOST ALL ACTIVITIES	CAN DO MOST ACTIVITIES	CAN DO SOME ACTIVITIES	CAN DO A FEW ACTIVITES	CANNOT DO ANY ACTIVITES
7. Frequency of pain	NEVER ANY PAIN	OCCASIONAL PAIN 10% OF DAY	OCCASIONAL PAIN 25% OF DAY	INTERMITTENT PAIN 50% OF DAY	FREQUENT PAIN 75% OF DAY	CONSTANT PAIN 100% OF DAY
8. Lifting	NO PAIN WITH HEAVY WEIGHT	INTERMITTENT PAIN WITH HEAVY WEIGHT	↑ PAIN WITH HEAVY WEIGHT	↑PAIN WITH MODERATE WEIGHT	↑PAIN WITH LIGHT WEIGHT	↑PAIN WITH ANY WEIGHT
9. Walking	NO PAIN ANY DISTANCE	↑PAIN AFTER LONG DISTANCE	↑ PAIN AFTER 1 MILE	↑ PAIN AFTER ½ MILE	↑PAIN AFTER ½ HOUR	↑PAIN WITH ALL WALKING
10.Standing	NO PAIN AFTER SEVERAL HOURS	↑PAIN AFTER SEVERAL HOURS	↑PAIN AFTER 2 HOURS	↑PAIN AFTER 1 HOUR	↑ PAIN AFTER ½ HOUR	↑PAIN WITH ANY STANDING
11. Other : __________ Please fill in if There is another ADL That is not listed	NO PAIN AFTER SEVERAL HOURS	↑ PAIN AFTER 3 OR MORE HOURS	↑PAIN AFTER 2 HOURS	↑PAIN AFTER 1 HOUR	↑PAIN AFTER ½ HOUR	↑ PAIN WITH ANY________

Patient Signature: ______________________________________ Dr. Initials: ______________ Date: _________