CHIROPRACTIC

SPORTS THERAPY

CENTER

DAILY ACTIVITIES AND PAIN SCALE QUESTIONNAIRE

PATIENT NAME **TODAY'S DATE**

Mark each of the activities which you have difficulty performing and/or can perform only with pain.

For difficulty - use the letter **D**. For pain - use the letter **P**. For difficulty with pain - use **DP**.

HOUSEWORK

_____ Doing Laundry
_____ Making Beds
_____ Vacuuming
_____ Washing Dishes
_____ Ironing
_____ Carrying Groceries
_____ Caring for Pets
_____ Cooking
_____ Other, Please list below

YARD WORK

_____ Mowing lawn
_____ Shoveling snow
_____ Raking leaves
_____ Gardening
_____ Other, Please list below

ACTIVE

_____ Exercising
_____ Swimming
_____ Other, Please list below

GENERAL

_____ Walking
_____ Standing
_____ Running
_____ Sitting
_____ Sitting in recliner
_____ Lifting
_____ Bending
_____ Pulling
_____ Pushing
_____ Kneeling
_____ Climbing Stairs
_____ Reading
_____ Using telephone
_____ Chewing
_____ Lying in Bed
_____ Sleeping
_____ Sexual intercourse
_____ Getting up from chair/bed
_____ Playing piano
_____ Using computer/ typewriter
_____ Other, Please list below

PERSONAL GROOMING

_____ Combing hair
_____ Shaving
_____ In/Out of Bathtub
_____ Brushing Teeth
_____ Other, Please list below

TRAVEL

_____ Driving
_____ Riding (passenger)
_____ Minutes / day in each type of vehicle
_____ Auto
_____ Train
_____ Bus
_____ Truck
_____ Airplane
_____ Getting in and out of auto
_____ Other, Please list below

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose.

PAIN SEVERITY SCALE

Please state the area of pain. (If more than one area, please indicate and mark each area individually.)

Rate the severity of your pain by marking one box on the following scale:

NO PAIN | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | EXCRUCIATING PAIN

PATIENT'S SIGNATURE **DATE**