



Quality of Life Assessment During Activities of Daily Living

Rate your current difficulties in how the pain is affecting you by placing a check mark in the appropriate box.

If an activity does not cause pain or if pain does not affect an activity, leave box blank.

Physical Activities

- | | | | | |
|-----------------------------------|---------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> standing | <input type="checkbox"/> walking | <input type="checkbox"/> reaching | <input type="checkbox"/> bending right | <input type="checkbox"/> twisting right |
| <input type="checkbox"/> sitting | <input type="checkbox"/> squatting | <input type="checkbox"/> bending left | <input type="checkbox"/> twisting left | <input type="checkbox"/> reclining |
| <input type="checkbox"/> kneeling | <input type="checkbox"/> bending back | <input type="checkbox"/> looking left | <input type="checkbox"/> looking right | <input type="checkbox"/> sleeping/rest |

Functional Activities

- | | | |
|---|---|---|
| <input type="checkbox"/> carrying small objects | <input type="checkbox"/> pushing/pulling while standing | |
| <input type="checkbox"/> carrying large objects | <input type="checkbox"/> climbing stairs/incline | <input type="checkbox"/> exercising upper body |
| <input type="checkbox"/> bending at the waist | <input type="checkbox"/> exercising lower body | <input type="checkbox"/> lifting object off floor |

Social and Recreational Activities

- | | | | | |
|----------------------------------|--|---|------------------------------------|----------------------------------|
| <input type="checkbox"/> bowling | <input type="checkbox"/> jogging | <input type="checkbox"/> swimming | <input type="checkbox"/> golfing | <input type="checkbox"/> dancing |
| <input type="checkbox"/> biking | <input type="checkbox"/> hunting/fishing | <input type="checkbox"/> competitive sports | <input type="checkbox"/> gardening | |
| <input type="checkbox"/> walking | <input type="checkbox"/> horse riding | <input type="checkbox"/> other: _____ | | |

Self Care and Personal Hygiene

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> brushing teeth | <input type="checkbox"/> putting on shoes | <input type="checkbox"/> eating | <input type="checkbox"/> doing laundry |
| <input type="checkbox"/> grooming hair | <input type="checkbox"/> making the bed | <input type="checkbox"/> putting on pants | <input type="checkbox"/> doing dishes |
| <input type="checkbox"/> washing face | <input type="checkbox"/> cooking | <input type="checkbox"/> taking out trash | |
| <input type="checkbox"/> going to toilet | <input type="checkbox"/> driving/sitting in car | | |

Patient Signature: _____ Date: _____