Blau Chiropractic Wellness Center

Activities Of Daily Living Assessment

Name: _____ **Date:**_____

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

Quality of health rating:_____

1 = "I can do it without any difficulty"
2 = "I can do it without much difficulty, despite some pain"
3 = "I can manage to do it by myself, despite marked pain"
4 = "I manage to do it, despite the pain, but only if I have help"
5 = "I cannot do it all, because of the pain"

PLEASE FILL IN ALL AREAS!
IF AN AREA DOESN'T APPLY, STILL MARK IT A "1".
This is for scoring purposes.

Difficulties with Self Care and Personal Hygiene Activities

Bathing _____
Showering _____
Washing _____
Drying Hair _____
Combing Hair _____
Washing face _____
Brushing teeth _____
Making bed _____
Putting on shirt _____
Putting on shoes _____
Tying shoes _____
Putting on pants _____
Preparing meals _____
Eating _____
Cleaning dishes _____
Taking out trash _____
Doing Laundry _____
Going to Toilet _____

Difficulties with Physical Activities

Standing _____
Sitting _____
Reclining _____
Standing for long periods _____
Walking _____
Stooping _____
Squatting _____
Kneeling _____
Reaching _____
Bending forward _____
Bending back _____
Bending left _____
Bending right _____
Walking for long periods _____
Sitting for long Periods _____
Twisting left _____
Twisting right _____
Leaning forward _____
Leaning back _____
Leaning left _____
Leaning right _____
Kneeling for long periods _____

Difficulties with Functional Activities

Carrying small objects _____
Carrying large objects _____
Carrying brief case _____
Carrying large purse _____
Lifting weights off floor _____
Lifting weights off table _____
Climbing stairs _____
Climbing inclines _____
Pushing things while seated _____
Pushing things while standing _____
Pulling things while seated _____
Pulling things while standing _____
Exercising upper body _____
Exercising lower body _____
Exercising arms _____
Exercising legs _____

Difficulties with Social and Recreational Activities

Bowling _____
Golfing _____
Jogging _____
Dancing _____
Swimming _____
Skiing _____
Ice Skating _____
Roller Skating _____
Competitive Sports _____
Hobbies _____
Dating _____
Dining out _____

Difficulties with Traveling

Driving a motor vehicle _____
Driving for long periods of time _____
Riding as a passenger in a motor vehicle _____
Riding as a passenger on an airplane _____
Riding as a passenger on a train _____
Riding as a passenger for long periods _____

Please turn page over and fill out back.

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Activities Of Daily Living Assessment Page 2

Use the following **1 to 5** scale to describe the difficulties below.

1 = "This area is not affected by my condition"
2 = "This area is slightly affected by my condition"
3 = "My condition moderately restricts my ability in this area"
4 = "My condition seriously limits my ability in this area"
5 = "My condition prevents me from using this ability"

Difficulties With Different Forms Of Communication

Concentrating _____
Hearing _____
Listening, Concentrating _____
Speaking _____
Reading _____
Writing _____
Using a keyboard _____

Difficulties With The Senses

Seeing _____
Hearing _____
Sense of touch _____
Sense of taste _____
Sense of smell _____

Difficulties With Hand Functions

Grasping _____
Holding _____
Pinching _____
Sensory discrimination _____

Difficulties With Sleep and Sexual Function

Being able to have normal, restful nights sleep _____
Being able to participate in desired sexual activity _____

Write in below any additional information regarding your Activities Of Daily Living that wasn't covered above.

_____

_____

_____

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