Daily Activity/Living Form

Name: _____ **Date**: _____

Please rate the pain you have when doing the activities listed below. Use a pain scale of 1-10 (10=severe) Write the number beside the activity. If an activity does not cause any pain, leave it blank.

Personal care:

____bathing	____showering	____washing hair	____drying hair
____combing hair	____brushing teeth	____making bed	____ putting on shirt
____putting on shoes	____ taking off shoes	____tie shoes	____ putting on pants
____prepare a meal	____ eating	____clean dishes	____doing laundry
____take out trash	____ going to toilet	____ getting out of bed	____ turning over in bed

Physical Activity:

____ standing	____ sitting	____ reclining	____bending	____twisting
____ kneeling	____ reaching	____ walking	____exercise	____ lifting

Functional Activity:

____ caring a briefcase/purse	____ climbing steps	____ pushing a cart	____ sitting in a car
____ standing in a grocery	____ sitting at a computer	____reading	____ writing
____ focus/concentration			

Please list below any other daily activity or job activities that are affected by your pain. List as many as you can. As above, rate the pain and put a number beside the activity.

_____
_____
_____
_____
_____
_____
_____
_____
_____