

Blau Chiropractic Wellness Center

Activities Of Daily Living Assessment

Name: _____

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.

- 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"

**ONLY FILL IN
AREAS**

Difficulties with Self Care and Personal Hygiene Activities

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

Difficulties with Physical Activities

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

Difficulties with Functional Activities

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

Difficulties with Social and Recreational Activities

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

Difficulties with Traveling

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

Please turn page over and fill out back. 

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

Difficulties With The Senses

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

Difficulties With Hand Functions

Grasping _____ Pinching _____
Holding _____ 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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