KAISER CHIROPRACTIC, S.C.

ACTIVITIES OF DAILY LIVING - Revised

Patient Name: _____ File#: _____ Date: _____

Please fill out this form in ink. Select one answer for each question listed below. An answer is required for every question. If a question does not apply to you, please mark "I NEVER HAVE TO DEAL WITH THIS".

	I CAN DO THIS WITH NO PROBLEM	I CAN DO THIS, BUT IT MAKES MY SYMPTOMS WORSE	I CANNOT DO THIS WITHOUT-SOMEONE ELSE HELPING ME	I CANNOT DO THIS AT ALL	I NEVER HAVE TO DEAL WITH THIS
1. Getting in and out of bed	○	○	○	○	○
2. Rolling side to side in bed	○	○	○	○	○
3. Getting in and out of a chair	○	○	○	○	○
4. Grooming—brush teeth, comb hair, makeup, etc.	○	○	○	○	○
5. Getting in and out of the shower or tub	○	○	○	○	○
6. Light housekeeping—dusting, dishes, making beds	○	○	○	○	○
7. Reaching across counter	○	○	○	○	○
8. Reaching overhead	○	○	○	○	○
9. Caring for children	○	○	○	○	○
10. Grocery shopping	○	○	○	○	○
11. Cooking	○	○	○	○	○
12. Loading dishwasher	○	○	○	○	○
13. Gardening	○	○	○	○	○
14. Yard work—raking leaves, mowing the grass	○	○	○	○	○
15. Getting in and out of a car	○	○	○	○	○
16. Driving to the store or doctor's office	○	○	○	○	○
17. Leave Blank					●
18. Stairs (going up and down)	○	○	○	○	○
19. Reaching down to pick something up off the floor.	○	○	○	○	○
20. Heavy housekeeping—floors, vacuuming, laundry	○	○	○	○	○
21. Dressing—shoes, socks, slacks, shirt	○	○	○	○	○
22. Outdoor recreational activities	○	○	○	○	○

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