SeaCoast
FAMILY CHIROPRACTIC

Patient Name: _____ Date: _____/_____/_____

Signature: _____

New injuries/complaints: _____

Activities Scale

Activities	**No Pain**	**Intermittent**	**Moderate**	**Can't Perform**	**Rate Pain Level 1-10**
Walking					
Sitting					
Bending					
Standing					
Laying down					
Lifting					
Exercising					
Stairs					
Push/Pull					
Driving					
Dressing					
Housework					
Computer					
Gardening					
Sports					
Working					

Additional comments or concerns that could help us serve you better:

_____

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