FUNCTIONAL DIFFICULTY IN PERFORMING ACTIVITIES OF DAILY LIVING (A.D.L.'s)

Patient's Name____ Acct. #:________________________

How does your condition(s) currently interfere with your life and ability to function?
Place appropriate number from the key on corresponding line. Please put a score for each function listed.

(KEY: No effect = 0 Mild effect = 1 Moderate effect = 2 Severe effect = 3)

Function	**Date**	**Date**	**Date**
	________	________	________
Sitting	________	________	________
Rising out of a chair	________	________	________
Standing	________	________	________
Walking	________	________	________
Lying down	________	________	________
Bending over	________	________	________
Climbing stairs	________	________	________
Using a computer	________	________	________
Getting in/out of car	________	________	________
Driving car	________	________	________
Looking over shoulder	________	________	________
Caring for family	________	________	________
Grocery shopping	________	________	________
Household chores	________	________	________
Lifting objects	________	________	________
Reaching overhead	________	________	________
Showering or bathing	________	________	________
Dressing myself	________	________	________
Love life	________	________	________
Getting to/staying asleep	________	________	________
Getting in/out of bed	________	________	________
Exercising	________	________	________
Yard work	________	________	________
Other: ______________	________	________	________
Total Score:	________	________	________

Is there anything else the Doctor should know about your current condition, your progress or ways your current condition is affecting your life? ____
____.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

____ ________________________________
Signature Date (MM/DD/YYYY) / Initial