Rudi E. Ide & Associates

ACTIVITIES	NOT LIMITED	SLIGHTLY LIMITED	MODERATELY LIMITED	EXTREMELY LIMITED
1. Household tasks such as washing dishes (pots and pans), unloading dishwasher, pushing a vacuum cleaner, standing for meal preparation, cooking, making a bed.				
2. Performing shopping tasks, lifting or carrying groceries and/or laundry, opening doors.				
3. Climbing one flight of stairs or more, going up and down a curb.				
4. Bending, kneeling, or squatting.				
5. Bathing or dressing, grooming/personal hygiene, personal care/showering.				
8. Transfer in/out of bed, chair, shower, or car.				

SLEEP DISTURBANCE	YES	NO
8. Does the pain wake you or interrupt you sleep patterns?		
9. Do you require medications to sleep? If so, please name medicine:		
10. Do you live alone?		
11. Do you need assistance with activities of daily living?		
12. Is your social life restricted due to pain?		

ACTIVITY	30 min or more	15-30 min	0-15 min	None
11. Standing: Indicate amount of standing time, pain free.				
12. Walking: Indicate amount of walking time, pain free.				
13. Sitting: Indicate amount of sitting time, pain free.				

What social activities do you participate in, i.e., cards, eating out, etc.

What sports/daily activities to you participate in, i.e., health club, swimming, biking, golf, tennis, walking, running, etc.

Please indicate how often you participate in above activities and how many days per week?

Please list any other specific difficulties noted during your daily activities.

What personal goals do you hope to achieve with physical therapy?

PT.ADLquestion

PATIENT NAME: _____ DATE _____

PATIENT SIGNATURE _____