**Patient Registration & Health History**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: [ ]  Male [ ]  Female

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_ Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Primary Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Single [ ]  Married [ ]  Divorced [ ]  Widowed Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ In Case of Emergency Call\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Have you ever had Chiropractic care before? Yes [ ]  No [ ]  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Information**

Name of party responsible for payment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have health insurance? Yes [ ]  No [ ]  Name of company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* If reason for visit is an auto accident, please provide: Auto Insurance Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you want us to bill to your Insurance, please sign this Assignment and Release**
I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_\_\_\_\_\_\_ and assign directly to Dr.Jonathan Zuchowski, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions . The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies ) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s or guardian’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Why Chiropractic**? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your doctor will weigh your needs and desires when recommending your treatment program. Please check the box for the type of care that best meets your needs.

🡨[ ]

RELIEF CARE:

 Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it.

CORRECTIVE CARE:

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

 [ ] 🡪

**Health History**

Do you have any allergies? [ ] Yes [ ] No if yes Specify type(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Check All Current Problems You Have:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ] Dizziness[ ] Headaches[ ]  Vertigo[ ]  Ear Infections[ ]  Nausea[ ]  TMJ[ ]  Neck Pain[ ]  Migraines[ ]  Throat Issues [ ]  Chronic Sinus [ ]  Loss of Consciousness | [ ]  Asthma [ ]  Numbness in Arms[ ]  Numbness in Hands[ ]  Mid Back Pain[ ]  Shoulder pain[ ]  Arm Pain [ ]  Chest Pain [ ]  Nasua/Vomiting[ ]  Heart Disorders[ ]  High/low Blood Pressure[ ]  Liver Disease  | [ ]  Stomach Disorders[ ]  Bladder Problems[ ]  Thyroid Problems[ ]  Kidney Problems[ ]  Low Back Pain[ ]  Numbness in Legs[ ]  Numbness in Feet[ ]  Sciatica [ ]  Leg Pain[ ]  Knee Pain [ ]  Hip Pain  | [ ]  Anxiety[ ]  ADHD/ADD[ ]  Depression [ ]  Nervousness[ ]  Epilepsy[ ]  Infertility[ ]  Menstrual Disorder[ ]  Chronic Fatigue [ ]  Gastric Reflux [ ]  Lupus [ ]  Fibromyalgia | [ ]  Diabetes[ ]  Disc Problem[ ]  Broken/Fractured bones [ ]  Gout [ ]  Constipation/ Diarrhea [ ]  Other: 1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Family Health History**

Family History: Please write who the relation is and how old they were when had the disease, including yourself.

Alzheimer’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Headache \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Backache \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Disease\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Depression\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stroke\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dementia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes (1/ 2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Osteoporosis\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spinal Surgery\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anxiety \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abdominal Aortic Aneurysm (AAA):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician**:

 Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prescription Medications**:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date started \_\_\_/\_\_\_/\_\_\_\_\_ date stopped \_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date started \_\_\_/\_\_\_/\_\_\_\_\_ date stopped \_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date started \_\_\_/\_\_\_/\_\_\_\_\_ date stopped \_\_\_/\_\_\_/\_\_\_\_ Please list any additional medications on the back of this form Vitamins / Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ prescribed by Dr? Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ prescribed by Dr? Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ prescribed by Dr? Y N

**History of Health Concerns**

*If you have additional symptoms (3+) and require another symptom sheet, please ask for an “Additional Symptom” form*

Please start at the top of your body and work your way down

Please mark on the diagram with the following letters to describe your symptoms:

**R**=Radiating **B**=Burning **D**=Dull **A**=Aching **S**=Sharp/Stabbing **T**=Tingling **N**=Numbness



Symptom 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• On a scale of 1 – 10, 10 being the worst pain you’ve ever felt,

what is the severity of your symptom?

1 2 3 4 5 6 7 8 9 10

 • What percent of the time do you feel the symptom?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

• When did this episode begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Did it begin: [ ]  Suddenly [ ]  Gradually

• Describe how it began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Have you had the symptom in the past before? [ ]  Yes [ ]  No

• If yes, when was the first time you’ve ever felt the symptom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • What makes the symptom worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • What makes the symptom better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Does the pain radiate? [ ]  Yes [ ]  No

• If yes, describe in detail where it radiates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Does the pain feel worse at a particular time of day? [ ]  Morning [ ]  Afternoon [ ]  Early evening [ ]  Late at night [ ]  Unchanged by time of day

Symptom 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark on the diagram with the following letters to describe your symptoms:

**R**=Radiating **B**=Burning **D**=Dull **A**=Aching **S**=Sharp/Stabbing **T**=Tingling **N**=Numbness



• On a scale of 1 – 10, 10 being the worst pain you’ve ever felt,

what is the severity of your symptom?

1 2 3 4 5 6 7 8 9 10

 • What percent of the time do you feel the symptom?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

• When did this episode begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Did it begin: [ ]  Suddenly [ ]  Gradually

• Describe how it began \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Have you had the symptom in the past before? [ ]  Yes [ ]  No

• If yes, when was the first time you’ve ever felt the symptom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 • What makes the symptom worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • What makes the symptom better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Does the pain radiate? [ ]  Yes [ ]  No

• If yes, describe in detail where it radiates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

• Does the pain feel worse at a particular time of day? [ ]  Morning [ ]  Afternoon [ ]  Early evening [ ]  Late at night [ ]  Unchanged by time of day

**Patients Desire for Care Outcomes(s)**

Are you interested in anything in particular as a result of your care, if so, please list below

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

**Smoking**: [ ] Cigars [ ] Pipe [ ] Cigarettes [ ] E-Cigarettes **🡪** **How Often?** [ ] Daily [ ] Weekends [ ] Occasionally [ ] Never **Alcoholic Beverages**: Consumption occurs: **🡪** [ ] Daily [ ] Weekends [ ] Occasionally [ ] Never **Recreational Drug Use**: **🡪** [ ] Daily [ ] Weekends [ ] Occasionally [ ] Never **Caffeine intake**: [ ]  Coffee [ ] Tea [ ] Energy Drink **🡪** [ ] Daily [ ] Weekends [ ] Occasionally [ ] Never **Do you exercise?** [ ] Yes [ ] No  **🡪**  1x 2x 3x 4x 5x per week Other\_\_\_\_\_\_\_\_\_ **If Yes Than What Activities?** [ ] Running/ Walking [ ] Weight Training [ ] Cycling [ ] Yoga/Pilates [ ] Other\_\_\_\_\_\_\_\_\_ **Hobbies** How does your present problem affect the following: [ ] Recreational Activities [ ] Exercise Regime *Please Explain*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities of Life**

*Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activities**  | **No Effect** | **Painful (can do)** | **Painful (limits)**  | **Unable to Perform** |
| Carrying Groceries  |  |  |  |  |
| Lifting Groceries  |  |  |  |  |
| Sit to Stand  |  |  |  |  |
| Climbing Stairs  |  |  |  |  |
| Pet Care |  |  |  |  |
| Driving  |  |  |  |  |
| Extended Computer Use  |  |  |  |  |
| Household Chores  |  |  |  |  |
| Lifting Children |  |  |  |  |
| Concentration (reading)  |  |  |  |  |
| Bathing |  |  |  |  |
| Dressing |  |  |  |  |
| Shaving  |  |  |  |  |
| Sexual Activities |  |  |  |  |
| Sleep |  |  |  |  |
| Static Siting  |  |  |  |  |
| Static Standing  |  |  |  |  |
| Yard Work |  |  |  |  |
| Walking  |  |  |  |  |
| Washing/Bathing |  |  |  |  |
| Sweeping/ Vacuuming |  |  |  |  |
| Dishes |  |  |  |  |
| Laundry |  |  |  |  |
| Garbage |  |  |  |  |
| Dressing |  |  |  |  |
| Other:  |  |  |  |  |