Activities of Daily Living Assessment

Name: _____ **Date:** _____

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and WRITE IN THE APPROPRIATE NUMBER that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty"
2 = "I can do it without much difficulty, despite some pain"
3 = "I manage to do it by myself, despite marked pain"
4 = "I manage to do it, despite the pain, but only if I have help"
5 = "I cannot do it all, because of the pain"

Only fill in areas affected.

Difficulties with Self Care and Personal Hygiene Activities

Bathing____ Drying hair____ Brushing teeth____ Putting on shoes____ Preparing meals____ Taking out trash____
Showering____ Combing hair____ Making bed____ Tying shoes____ Eating____ Doing laundry____
Washing hair____Washing face____ Putting on shirt____ Putting on pants____ Cleaning dishes____ Going to toilet____

Difficulties with Physical Activities

Standing____ Walking____ Kneeling ____ Bending back ____ Twisting left____ Leaning back____
Sitting____ Stooping____ Reaching____ Bending left____ Twisting right____ Leaning left____
Reclining____ Squatting____ Bending forward____Bending right____ Leaning forward____ Leaning right____
Standing for long periods____ Sitting for long periods____ Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities

Carrying small objects____ Lifting weights off floor____ Pushing things while seated____ Exercising upper body____
Carrying large objects____ Lifting weights off table____ Pushing things while standing____ Exercising lower body____
Carrying brief case____ Climbing stairs____ Pulling things while seated____ Exercising arms____
Carrying large purse____ Climbing inclines____ Pulling things while standing____ Exercising legs____

Difficulties with Social and Recreational Activities

Bowling____ Jogging____ Swimming____ Ice Skating____ Competitive Sports____ Dating____
Golfing____ Dancing____ Skiing____ Roller Skating____ Hobbies____ Dining out____

Difficulties with Travelling

Driving a motor vehicle____ Riding as a passenger in a motor vehicle____ Riding as a passenger on a train____
Driving for long periods of time____ Riding as a passenger on an airplane____ Riding as a passenger for long periods____

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful sleep____ Being able to participate in desired sexual activity____

Write any additional information regarding your Activities of Daily Living that wasn't covered above on the back of this page.

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