ACTIVITIES OF DAILY LIVING ASSESSMENT

Use the following scale of 1 to 5 to describe the difficulties below or mark an "X" if the activity does not apply to you:
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 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 Traveling

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....___

Difficulties with Different Forms of Communication

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 nights sleep.........___ Being able to participate in desired sexual activity.........___

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Signature___________________________________ **Date**____________________

Print Name___________________________________