ACTIVITIES OF DAILY LIVING

Name: ___________________________ Date:__________________________

How much does your injury interfere with the following activites?

Please mark the Difficulty range column for each item.

	Without Difficulty	**With Some Difficulty**	**With Much Difficulty**	**Unable To Do**
Self-care and Personal Hygiene:				
Getting on/off toilet	_____	_____	_____	_____
Wiping yourself after using toilet				
Urinating				
Defecating				
Brunshing Teeth				
Combing/brushing hair				
Washing/drying yourself				
Dressing yourself				
Tying shoes				
Physical Activites:				
Sitting				
Reclining				
Rising up from chair				
Standing				
Walking				
Climbing Stairs				
Working outdoors on flat ground				
Light housework including laundry				
Lifting				
Hand Activities:				
Grasping/Gripping				
Open milk carton				
Open previously opened jars				
Turn faucets on and off				
Open a car door				
Lifting				
Lift full cup/bottle/glass to mouth				
Make a meal				
Eating				
Cut food				

Name: <first> <last> Date:________________________

How much does your injury interfere with the following activites?

Please mark one column for each item.

	Without	**With Some**	**With Much**	**Unable**
Travel:				
Riding in a motor vehicle				
Driving a motor vehicle				
Getting in/out of car				
Flying				
Sexual Function:				
Engage in sexual function				
Sleep:				
Restful Sleep				
Fatigue during the day				
Communitcation:				
Writing				
Typing				
Sensory Function:				
Feel what you touch				
Tasting				
Smelling				
Hearing				
Seeing				