ROCKLAND PHYSICAL THERAPY

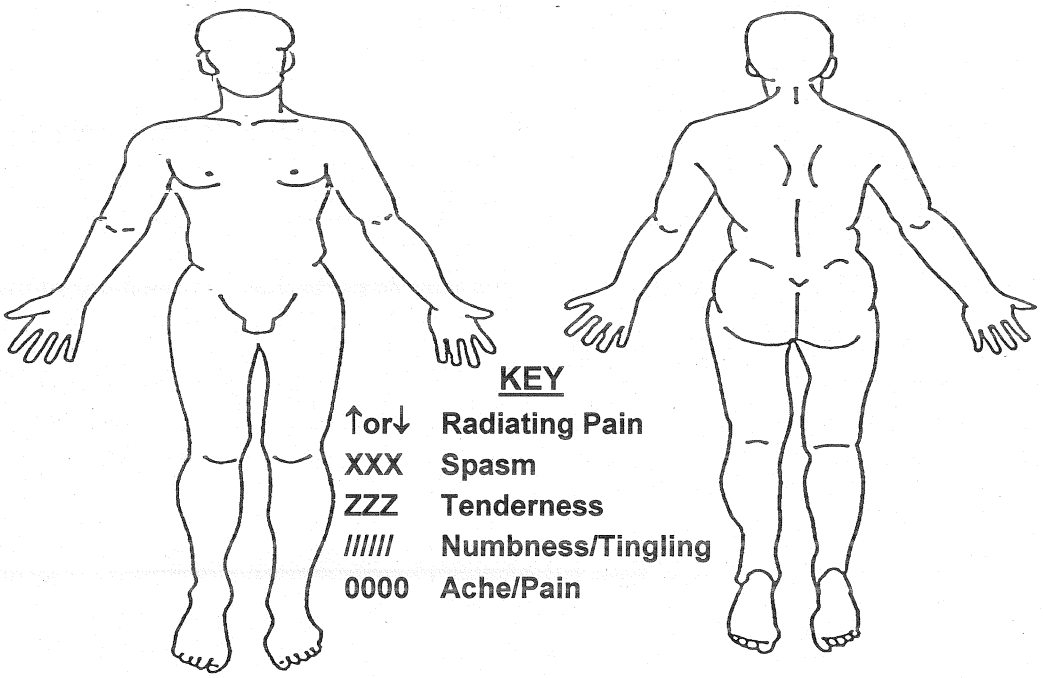
# BODY/PAIN CHART AND ACTIVITY OF DAILY LIVING SCREEN

PATIENT NAME: _____

**COMMENTS/REMARKS:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Indicate where you have pain or other symptoms:**




**Please answer the following questions as it relates to your current problem.**

1. Check off all of the pain descriptions below that apply:

☐ increases with prolonged sitting ☐ increases with prolonged standing ☐ during driving
☐ with routine household activities ☐ getting up from a chair ☐ getting up out of bed
☐ overhead reaching ☐ reaching behind

a. Pain is Worse: ☐ in the morning ☐ during the day ☐ at night ☐ constant

b. Increase with specific movements or activities (Describe): _____

c. What helps relieve your pain? _____

2. Do you have trouble with walking? ☐ Yes ☐ No If yes, how far can you walk without pain? _____

3. Are you unable to perform any of the following activities? Do you have problems with or have you changed your method of performing any of the following tasks? Check all that apply.

| | | | | |
|---|---|---|---|---|
| ☐ Getting in/out of bed | ☐ Personal hygiene activities | ☐ Eating | ☐ Shaving | ☐ Cleaning |
| ☐ Getting in/out of a car | ☐ Bathing/Shower | ☐ Sleeping | ☐ Lifting | ☐ Writing |
| ☐ Getting in/out of a chair | ☐ Brushing teeth | ☐ Sitting | ☐ Cooking | ☐ Shopping |
| ☐ Walking up/down stairs | ☐ Dressing | ☐ Standing | ☐ Laundry | ☐ Driving |
| ☐ Getting in/out of shower | ☐ Work Activities | ☐ Walking | ☐ Vacuuming | |

☐ Other: _____

_____ _____

**Patient/Guardian Signature** **Date**