

# Health From Within Chiropractic

## Activities of Daily Living/Symptoms/Medications

**Patient Name:** \_\_\_\_\_

**File#** \_\_\_\_\_

**Date:** \_\_\_\_\_

### Daily Activities: Effects of Current conditions On Performance

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

Bending	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Concentrating	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing computer Work	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Gardening	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Playing Sports	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Recreation Activities	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Shoveling	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sleeping	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Watching TV	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Carrying	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dancing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Dressing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Lifting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Pushing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Rolling Over	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Working	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Climbing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Doing Chores	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Driving	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Performing Sexual Activity	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Reading	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Running	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
Sitting to Standing	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform

## Health From Within Chiropractic

Walking	<input type="checkbox"/> No Effect	<input type="checkbox"/> Painful (can do)	<input type="checkbox"/> Painful (Limits)	<input type="checkbox"/> Unable to Perform
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**Please mark P for in the Past, C for Currently have and N for Never**

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|--|----------------------------|---------------------|------------------------------|--------------------------|
| ___ Headache                           | ___ Pregnant (Now)         | ___ Dizziness       | ___ Prostate Problems        | ___ Ulcers               |
| ___ Neck Pain                          | ___ Frequent Colds/Flu     | ___ Loss of Balance | ___ Impotence/Sexual Dysfun. | ___ Heartburn            |
| ___ Jaw Pain, TMJ                      | ___ Convulsions/Epilepsy   | ___ Fainting        | ___ Digestive Problems       | ___ Heart Problem        |
| ___ Shoulder Pain                      | ___ Tremors                | ___ Double Vision   | ___ Colon Trouble            | ___ High Blood Pressure  |
| ___ Upper Back Pain                    | ___ Chest Pain             | ___ Blurred Vision  | ___ Diarrhea/Constipation    | ___ Low Blood Pressure   |
| ___ Mid Back Pain                      | ___ Pain w/Cough/Sneeze    | ___ Ringing in Ears | ___ Menopausal Problems      | ___ Asthma               |
| ___ Low Back Pain                      | ___ Foot or Knee Problems  | ___ Hearing Loss    | ___ Menstrual Problem        | ___ Difficulty Breathing |
| ___ Hip Pain                           | ___ Sinus/Drainage Problem | ___ Depression      | ___ PMS                      | ___ Lung Problems        |
| ___ Back Curvature                     | ___ Swollen/Painful Joints | ___ Irritable       | ___ Bed Wetting              | ___ Kidney Trouble       |
| ___ Scoliosis                          | ___ Skin Problems          | ___ Mood Changes    | ___ Learning Disability      | ___ Gall Bladder Trouble |
| ___ Numb/Tingling arms, hands, fingers |                            | ___ ADD/ADHD        | ___ Eating Disorder          | ___ Liver Trouble        |
| ___ Numb/Tingling legs, feet, toes     |                            | ___ Allergies       | ___ Trouble Sleeping         | ___ Hepatitis (A,B,C)    |

**List Prescription & Non-Prescription drugs you take:** \_\_\_\_\_

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