Name: _____ Date: _____

ACTIVITIES OF DAILY LIVING SURVEY:

Measuring your ability to perform daily activities at home can be filled out online, printed, and brought to the office. It will automatically sum the totals. This will help us compare your progress to your first visit. This survey only needs to be filled out on subsequent visits to your initial consultation to see Dr. Auerbach… He will advise you when to fill out this survey.

How does this condition currently interfere with your daily life and the ability to function?

On a scale of 0 - 10, 0 being No Effect and 10 being Severe Effect please complete the following.

Going to sleep	0	Walking	0	Reaching over head	0
Staying asleep	0	Standing	0	Looking over shoulder	0
Rising out of chair	0	Bending over	0	Household chores	0
Showering or bathing	0	Dressing myself	0	Using a computer	0
Driving a car	0	Sitting	0	Concentration / Balance	0

Reset?

Combined Total: **0**