Questions Concerning Activities of Daily Living (ADL)

Please fill out this form carefully and mark only one box for each question.

1. How well can you perform personal self care activities including washing, dressing, using the bathroom, etc.?

- ❒ I can look after myself normally without having extra discomfort.
- ❒ I can look after myself normally by have extra discomfort.
- ❒ It is uncomfortable to look after myself and I am slow and careful.
- ❒ I need some help but I manage most of my personal self care.
- ❒ I need help everyday in most aspects of my personal self care.
- ❒ I do not get dressed, I wash with difficulty and I stay in bed or lay down most of the day.

2. How well can you lift and carry?

- ❒ I can lift and carry heavy objects without having extra discomfort.
- ❒ I can lift and carry heavy objects but I get extra discomfort.
- ❒ I can lift and carry heavy objects only if they are conveniently positioned.
- ❒ I can only lift and carry light to medium objects if they are conveniently positioned.
- ❒ I can only lift very light objects.
- ❒ I cannot lift or carry anything at all.

3. How well can you walk?

- ❒ I am able to walk the same distance I could before my injury.
- ❒ My injury and discomfort prevents me from walking more than 1 mile.
- ❒ My injury and discomfort prevents me from walking more than 1/2 mile.
- ❒ My injury and discomfort prevents me from walking more than 1/4 mile.
- ❒ Because of my injury and discomfort I walk only a limited distance or I use a cane, crutches or walker.
- ❒ Because of my injury and discomfort I am in bed most of the time or use a wheelchair.

4. What is the most strenuous level of activity that you can do for at least 2 minutes?

- ❒ Very heavy activity
- ❒ Heavy activity
- ❒ Moderate activity
- ❒ Light activity
- ❒ Very light activity
- ❒ Extremely light to no activity

5. How well can you climb a flight of stairs?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity or someone else helps you with it)

6. How well can you sit for 30 minutes to an hour?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity)

7. How well can you sit for 2 hours?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity)

8. How well can you stand or walk 30 minutes to an hour?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity)

9. How well can you stand or walk for 2 hours?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity)

10. How well can you reach and grasp something off a shelf at eye level?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity or someone else helps you with it)

11. How well can you reach and grasp something off a shelf overhead?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity or someone else helps you with it)

12. Do you have any difficulty with pushing and pulling activities?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity or someone else helps you with it)

13. Do you have any difficulty with gripping, grasping, holding and manipulating objects with your hands?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity or someone else helps you with it)

14. Do you have any difficulty with repetitive motions such as typing on a computer?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity or someone else helps you with it)

15. Do you have any difficulty with forceful activities with your arms and hands?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity or someone else helps you with it)

16. Do you have any difficulty with kneeling, bending or squatting?

- ❒ No difficulty (and you can easily perform the activity)
- ❒ Some difficulty (but you can still perform the activity well enough)
- ❒ A lot of difficulty (but you can still do the activity)
- ❒ Unable (you cannot do this activity or someone else helps you with it)

17. Do you have any difficulty with sleeping?

- ❒ I have no trouble sleeping because of my injury and discomfort.
- ❒ My sleep is slightly disturbed (less than 1 hour sleepless) since my injury
- ❒ My sleep is mildly disturbed (1-2 hours sleepless) since my injury
- ❒ My sleep is moderately disturbed (2-3 hours sleepless) since my injury
- ❒ My sleep is greatly disturbed (3-5 hours sleepless) since my injury
- ❒ My sleep is completely disturbed (5-7 hours sleepless) since my injury

18. In regards to sexual activity since and because of your injury?

- ❒ It is not a problem and there has not been a change because of my injury
- ❒ It is a little less frequent because of my injury
- ❒ It is much less frequent because of my injury
- ❒ No sexual functioning because of my injury

19. In regards to your pain <u>at the moment</u>?

- ❒ I have no pain at the moment
- ❒ My pain is mild at the moment
- ❒ My pain is moderate at the moment
- ❒ My pain is severe at the moment
- ❒ My pain is the worst imaginable at the moment

20. In regards to your pain <u>most of the moment</u>?

- ❒ I have no pain most of the time
- ❒ My pain is very mild most of the time
- ❒ My pain is moderate most of the time
- ❒ My pain is fairly severe most of the time
- ❒ My pain is the worst imaginable most of the time

21. How much do your injury and/or pain interfere with your ability to travel?

- ❒ None
- ❒ Some or a little of the time
- ❒ A lot or most of the time
- ❒ All of the time – I can't travel

22. How much do your injury and/or pain interfere with your ability to engage in social activities?

- ❒ None
- ❒ Some or a little of the time
- ❒ A lot or most of the time
- ❒ All of the time – I can't engage in social activities

23. How much do your injury and/or pain interfere with your ability to engage in recreational activities?

- ❒ None
- ❒ Some or a little of the time
- ❒ A lot or most of the time
- ❒ All of the time – I can't engage in recreational activities

24. How much do your injury and/or pain interfere with concentrating or thinking?

- ❒ None
- ❒ Some or a little of the time
- ❒ A lot or most of the time
- ❒ All of the time – I can't concentrate or think very clearly

25. How much has your injury and/or pain caused emotional distress with depression or anxiety?

- ❒ None (no depression or anxiety from the injury or discomfort)
- ❒ Some or a little of the time (mild depression or anxiety from the injury or discomfort)
- ❒ A lot or most of the time (moderate depression or anxiety from the injury or discomfort)
- ❒ All of the time (severe depression or anxiety from the injury or discomfort)

Work & Functional Capacity Activity Estimation Summary

ACTIVITY (Hours per Day)	NEVER 0 hours	SOME <1 hour	OCCASIONALLY 1-3 hours	FREQUENTLY 3-6 hours	CONSTANTLY 6-8+ hours
Repetitive neck motions					
Static neck posturing					
Bending / Twisting (waist)					
Squatting & kneeling					
Sitting					
Standing					
Walking					
Climbing stairs					
Climbing ladders					
Walking over uneven ground					
Working at heights					
Working around moving machinery					
Repetitive use of upper extremity (right)					
Repetitive use of upper extremity (left)					
Grasping / Gripping (right hand)					
Grasping / Gripping (left hand)					
Forceful use of upper extremity (right)					
Forceful use of upper extremity (left)					
Fine manipulation (right hand)					
Fine manipulation (left hand)					
Pushing & Pulling (right) - in pounds					
Pushing & Pulling (left) - in pounds					
Reaching (at shoulder level)					
Reaching (above shoulder level)					
Lifting / Carrying - in pounds					

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Demographic Intake Form

Today's Date: _____

Name: _____ ☐ M ☐ F Birth date: _____ SS#: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail address: _____

Is English your first language? ☐ Yes ☐ No If no, what language? _____

Current Marital Status: ☐ S ☐ M ☐ W ☐ D

Primary Care Physician: _____ Phone:_____

Referred by: _____ Phone: _____

Other physicians or health care providers that you have seen or are currently seeing, including chiropractors, therapists, etc.

Name: _____ Specialty: _____

Address: _____ Phone: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

INSURANCE INFORMATION (*Non Worker's Compensation*)

Primary Insurance Subscriber: ☐ Self ☐ Spouse ☐ Parent Employer Name: _____

Subscriber's Name: _____ SS/ID#: _____ D.O.B.: _____

Name of Insurance: _____ ID#: _____ Group#: _____

Address to submit claims: _____ Telephone: _____

Secondary Insurance

Subscriber's Name: _____ SS/ID#: _____ D.O.B.: _____

Name of Insurance: _____ ID#: _____ Group#: _____

Address to submit claims: _____ Telephone: _____

MEDICARE/MEDI-CAL

Do you subscribe to Medicare? ☐ Yes ☐ No If yes, Subscriber #: _____

Do you subscribe to MEDI-Cal? ☐ Yes ☐ No If yes, Subscriber #: _____

EMPLOYMENT INFORMATION

Current Employer: _____ Phone: _____

Address: _____ Date of Hire:_____

Occupation & Job Title: _____

Current Work Status: ☐ working ☐ full-time ☐ part-time ☐ regular work ☐ modified work ☐ not working

Hours worked per week: _____ Hours worked per day: _____

Describe your job duties: _____

I am: ☐ right handed ☐ left handed ☐ ambidextrous

WORK INJURIES

Is your pain related to a work injury: ☐ Yes ☐ No Date of Injury: _____

Job title at time of injury: _____

Have you filed a Workers' Compensation claim with this employer for this injury? ☐ Yes ☐ No

If yes, claim#: _____ Insurance Carrier: _____

Have you ever had a Workers' Compensation claim before? ☐ Yes ☐ No

If yes, please list separately all work injuries and body parts injured: _____

_____

List any other jobs or income source at the time of your injury: _____

Are you currently in litigation (lawsuit)? ☐ Yes ☐ No

Contact Person/Adjuster: _____ Phone: _____ Fax: _____

Address: _____

Employer at time of Injury: _____ Phone: _____ Fax: _____

Address: _____

Nurse Case Manager: _____ Phone: _____ Fax: _____

Address: _____

Patient's Attorney: _____ Phone: _____ Fax: _____

Address: _____

Employer's Attorney: _____ Phone: _____ Fax: _____

Address: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

I authorize the release of any medical information necessary to process this claim to the insurance company, attorney, or other physicians. I understand that I am responsible for all charges incurred. I further authorize my insurance to make direct payment to the Bay Area Pain Center for all medical benefits.

_____ _____

Patient Signature Date

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THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your personal physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would *never* doze or sleep.
1 = *slight* chance of dozing or sleeping
2 = *moderate* chance of dozing or sleeping
3 = *high* chance of dozing or sleeping

Please fill in your answers:

Situation	**Chance of Dozing or Sleeping**
Sitting and reading	____
Watching TV	____
Sitting inactive in a public place	____
Being a passenger in a motor vehicle for an hour or more	____
Lying down in the afternoon	____
Sitting and talking to someone	____
Sitting quietly after lunch (no alcohol)	____
Stopped for a few minutes in traffic while driving	____
Total score (add the scores up)	____

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PAIN HISTORY

What is the purpose of your visit? _____
Who has referred you? _____
Where is the pain located? _____
When did the pain start? _____
How did the pain first start? (Circle one)

- Suddenly Gradually Cumulative
- Accident Trauma Fall Injured at work Sports

Is this is a Workers Compensation injury? ❒ Yes ❒ No
What is the level of pain today if 0 is no pain and 10 is worst pain: _____/10
Is your pain constant or intermittent?
Nature of pain: dull achy sharp shooting burning pins/needles
What makes you pain worse?
What makes your pain better?
In the last 12 months how many times have you visited the ER for treatment of your Pain?
Is there a personal injury claim or litigation in relation to the current pain?
Have these activities been effected because of your pain: list yes or no

Household chores		Depression	
Office Work		Anxiety	
Drive		Mood	
Walk/Run		Appetite	
Sports		Sleep	
Concentration		Relationships	

What treatments have you tried in the past? List if it was effective.

_____
_____
_____

CURRENT MEDICATIONS

Name of Medication	Date Started	Prescribing Physician	Strength	Number of pills/day	Does it help? (yes/no)

ALLERGIES: _____

PAST SURGICAL HISTORY:

Type **Date** **Surgeon**

_____
_____
_____
_____

PAST MEDICAL, FAMILY HISTORY AND REVIEW OF SYSTEMS: (check box)

	You	Family		You	Family		You	Family
Stroke			Diabetes			Suicide ideation/attempts		
Seizures			High Blood Pressure			Depression/Bipolar		
Heart			Thyroid			Mental Disorders		
Lungs			Bleeding/ Anemia			Alcohol/Drug problems		
Liver			Stomach/ Bowel			State/ SS disability		
Kidney/Bladder			Fibromyalgia			Other		
Cancer			Gout					
Migraines			Arthritis					

PERSONAL AND SOCIAL HISTORY: Circle Yes/No. Please offer detailed answer if yes.

Do you work? Yes/No; Occupation: _____ Employer: _____
What is your highest level of education? _____
Are you ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed
Do you have children? How many? _____ Ages _____
Who do you live with? _____
Do you smoke? Yes/No; # of packs/day _____
Do you drink alcohol? Yes/No; how much? _____
Do you use recreational drugs? Yes/No; if yes, please elaborate _____
Have you ever abused drugs or alcohol in the past? Yes/No
Have you ever been treated at a drug or alcohol rehabilitation center? Yes/No

PAIN DIAGRAM: