



**ACTIVITIES OF DAILY LIVING - Page 2 of 2**

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

**TOLERANCE CHART**

Place an "X" in the box that best describes the amount of time you can perform each activity before pain either limits the activity or causes you to modify that activity.

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

	Avoid activity	0-15 min	30 min	45 min	1 hr	2 hrs	3 hrs	4 hrs	5 hrs	6 hrs	7 hrs	8 + hrs / no limitations	Pain Location
ability to sit													
ability to stand													
ability to walk													
ability to sleep													

**PAIN LEVEL CHART**

For your initial evaluation reflect on your pain for the past 30 days. For your re-evaluation reflect on your pain for the past 24 hours. The pain scale is 0-10 with 0 = no pain and 10 = the worst pain.

	Description (tight, sore, sharp, stabbing, shooting, tingly, numb, tender, ache, throbbing)	Intensity: 0-10 (none) 0 - 10 (severe)		Frequency D (Daily) O (Occasional) R (Rare)
		Worst	Best	
<b>Head</b>				
<b>Neck</b>				
<b>Chest</b>				
<b>Mid Back</b>				
<b>Lumbar</b>				
<b>Groin</b>				
<b>Buttocks</b>				
<b>Arms</b>				
Right				
Left				
<b>Legs</b>				
Right				
Left				

ADDITIONAL COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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