JOHNSON CITY CHIROPRACTIC CLINIC, P.C.

Patients Name: DKP#:

ACTIVITIES OF LIFE

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

ACTIVITIES:	EFFECT:			
Carrying Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sit to Stand	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing Stairs	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Pet Care	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Extended Computer Use	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Household Chores	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting Children	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Reading / Concentration	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Shaving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sexual Activities	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Static Sitting	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Static Standing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Walking	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Washing/Bathing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sweeping / Vacuuming	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dishes	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Laundry	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Yard Work	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Garbage	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Climbing Steps	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Lifting Groceries	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Dressing	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Sleep	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Driving	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform
Other:_____	❑ No Effect	❑ Painful (can do)	❑ Painful (limits)	❑ Unable to Perform

Please mark "P" for **in the PAST**, **"C"** for **CURRENTLY** have and **"N"** for **NEVER**

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

List Prescription and Non-Prescription drugs you take: _____

_____

_____

_____

Patient's Signature: _____ Date: _____