Patient Name _____ **Date**_____

Activities Discomfort Scale

Please mark with an X all that apply

Activity	**Doesn't Hurt At All**	**Hurts a little**	**Hurts Very Much**	**Almost Unbearable**	**Unbearable Pain Prevents Activity**
Walking					
Sitting					
Bending					
Standing					
Sleeping					
Lifting					
Running or jogging					
Climbing stairs					
Carrying					
Pushing and pulling					
Driving					
Dressing					
Reading					
Watching TV					
Household chores					
Gardening					
Sports					
Employment					

Total_____

Patient signature_____ Date_____