

**ACTIVITIES DISCOMFORT SCALE**

For each of the following activities, please place a check in the one column that best describes how much pain the activity presently causes, on the average (does not include unusual or prolonged activity)

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 OR PULLING					
DRIVING					
DRESSING					
READING					
WATCHING TV					
HOUSEHOLD CHORES					
GARDENING					
SPORTS					
EMPLOYMENT					

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

Patient Name \_\_\_\_\_ Patient Signature \_\_\_\_\_

Examiner \_\_\_\_\_ Date \_\_\_\_\_