Jessica W. Seaton, D.C.

PATIENT DAILY ACTIVITY SCHEDULE
(Subjective Functional Capacity)

NAME _____ DATE _____

Please circle the one best response for each activity described below:

Activities of Daily Living (bathing, dressing, feeding self, toilet)
1. Need some assistance
2. Slight difficulty
3. Minimal difficulty
4. No problem

Laundry
1. Unable
2. Occasionally
3. Regularly in small steps or with help
4. Regularly without help

Cooking
1. Unable
2. Take-out, breakfast, or simple lunch only
3. Simple microwave or crockpot meal
4. Regular meals

Housekeeping
1. Unable
2. Light dusting, straighten up
3. Regular housekeeping in small steps or with help
4. Regular

Grocery Shopping
1. Unable
2. Occasional (once or twice per month)
3. Frequent, but with assistance
4. No problem

Social Activities (church, temple, family and friends)
1. Unable
2. Infrequently
3. Occasionally (once or twice per month)
4. Frequently (weekly or more often)

Driving
1. Unable
2. Very limited
3. Cautious, local trips
4. Distant trips or traffic

Errands or Light Chores (examples: post office, drop off a child)
1. None
2. 0-1 per day
3. 2-3 per day
4. No or few restrictions

Score:_____