



Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

## Loss of Enjoyment/Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of the day-to-day **living or work duties that are painful or difficult for you to perform as a result of the injuries** you sustained. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities, which require that you reduce the time you are capable of performing them.

**Please Print Clearly in Black Ink**

Job description: \_\_\_\_\_

<b>N/A Work</b>	<b>Reason for the Difficulty/Limitation</b>		
_____ Lifting	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Bending	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Sitting	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Walking	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Computer Duties	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Other: _____	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform

<b>N/A Studies/School</b>	<b>Reason for the Difficulty/Limitation</b>		
_____ Lifting	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Bending	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Sitting	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Walking	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Computer Duties	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Studying	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Other: _____	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform

<b>N/A Domestic Duties</b>	<b>Reason for the Difficulty/Limitation</b>		
_____ Vacuuming	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Taking Care of Kids	<input type="checkbox"/> Increased Pain/Anxiety	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Cleaning	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Preparing Meals	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Other: _____	<input type="checkbox"/> Increased Pain/Anxiety	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform

<b>N/A Household Duties</b>	<b>Reason for the Difficulty/Limitation</b>		
_____ Yardwork	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Transportation	<input type="checkbox"/> Increased Pain/Anxiety	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Shopping	<input type="checkbox"/> Increased Pain/Anxiety	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Fatigue <input type="checkbox"/> Cannot Perform
_____ Taking Out Trash	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
_____ Other: _____	<input type="checkbox"/> Increased Pain	<input type="checkbox"/> Restricted Movement	<input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform

<b>N/A Sports</b>	<b>Reason for the Difficulty/Limitation</b>
Name Sport: _____	<input type="checkbox"/> Increased Pain <input type="checkbox"/> Restricted Movement <input type="checkbox"/> Weakness <input type="checkbox"/> Cannot Perform
Pre-Accident Level of Participation: _____	<input type="checkbox"/> Socially <input type="checkbox"/> Competitively <input type="checkbox"/> Professional

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_