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.

Job description: _____

N/A	Work	Reason for the Difficulty/Limitation
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
_____	Sitting	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
_____	Walking	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue □Cannot Perform
Other: _____		□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform

N/A	Studies/School	Reason for the Difficulty/Limitation
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
_____	Sitting	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
_____	Walking	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue □Cannot Perform
_____	Studying	□ Increased Pain □ Restricted movement □ Fatigue □Cannot Perform
Other: _____		□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform

N/A	Domestic Duties	Reason for the Difficulty/Limitation
_____	Vacuuming	□ Increased Pain □ Restricted movement □ Fatigue □Cannot Perform
_____	Taking care of kids	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue □Cannot Perform
_____	Cleaning	□ Increased Pain □ Restricted movement □ Fatigue □Cannot Perform
_____	Preparing Meals	□ Increased Pain □ Restricted movement □ Fatigue □Cannot Perform
_____	Other: _____	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue □Cannot Perform

N/A	Household Duties	Reason for the Difficulty/Limitation
_____	Yardwork	□ Increased Pain □ Restricted movement □ Fatigue □Cannot Perform
_____	Transportation	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue□Cannot Perform
_____	Shopping	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue□Cannot Perform
_____	Taking out trash	□ Increased Pain □ Restricted movement □ Weakness □Cannot Perform
Other: _____		□ Increased Pain/Anxiety □ Restricted movement □ Fatigue□Cannot Perform

N/A	Sports	Reason for the Difficulty/Limitation
Name Sport: _____		□ Increased Pain □ Restricted movement □ Weakness□Cannot Perform

Pre-accident level of participation: □ Socially □ Competitively □ Professional

Patient Signature: _____ Date: _____/_____/20___