210 South Street
Carrollton, Georgia 30117

(770) 834-6669

CONFIDENTIAL PATIENT HEALTH HISTORY

Your Title ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Miss ( ) Ms. ( ) Rev. ( ) Sister ( ) Rabbi

Full Name _____ *Preferred to be called:* _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____ Gender ( ) Male ( ) Female

Race ( ) Caucasian ( ) African American ( ) Hispanic ( ) Asian ( ) Am. Indian ( ) Unspecified ( ) Other

Check Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Home Phone _____ Work Phone _____

Cell Phone _____ Email Address _____

Social Security # _____

Work Status: ( ) Employed ( ) Unemployed ( ) Retired ( ) Student parttime ( ) Student fulltime

Employer _____ Occupation _____

Work Address _____

Referred by _____

Your Spouses' Name _____ # of Children _____

Spouse Employer _____ Spouses work phone _____

Name of person to contact in case of emergency _____ Relationship _____

Their home and work phone number _____

Name of nearest relative not living with you _____

Their phone number _____

Health Insurance ( ) Yes I am Insured ( ) I have NO insurance ( ) Yes but I don't know my info

Please hand INSURANCE CARD to front desk

Policy Holder ( ) Self ( ) Spouse ( ) Parent/Child ( ) Other

Insured Name _____

Insured Address _____

Insured City _____ State _____ Zip _____

Insured Birthdate _____ Insured Gender: ( ) Male ( ) Female

Insured Phone _____ Insured Employer _____

Is this an auto accident? Y/N Do you have an attorney Y/N

Firm Name _____ Attorney Name _____

Contact Person _____ Phone # _____

Address _____

Auto Insurance _____ Phone Adjuster _____

Claim Address _____

Claim # _____ Policy # _____ Med Pay Y/N Limitations _____

In order to determine if care can be of benefit to you, this office will extend the courtesy of an initial consultant without charge. If the doctor might be able to hep you with your condition, are you interested in seeking care? ( ) Yes ( ) Unsure

THERE WILL BE NO CHARGED SERVICES WITHOUT YOUR INFORMED CONSENT.

I attest that the above information is true and correct to the best of my knowledge. I further understand that any changes incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or statement.

Patient's Signature _____ Date _____

Parent or Guardian _____

Signature _____ Date _____

Present Complaints *(please circle the appropriate ones)*

Headache
Mental dullness
Loss of memory
Dizzy
Neck pain
Fainting
Upper back pain
Lower back pain
Neck restriction
Nervousness
Feet/hands cold

Depression
Rib Pain
Back stiffness
Shortness of breath
Upper back stiffness
Lower back stiffness
Eye strain/pain
Fear
Irritability
Head seems heavy
Confusion

Constipation
Unbalanced
Chest pain
Ears ringing/buzzing
Midback pain
Blurred vision
Loss of taste
Tension
Pins and needles in arms
Right / Left

Pins and needles in hands
Right Left
Pins and needles in legs
Right Left
Midback stiffness
Double vision
Loss of smell
Knee pain
Elbow pain
Hand/finger pain

Difficulty in: ( ) Standing ( ) Sitting ( ) Bending ( ) Walking

Pain radiating to: ( ) Right Arm ( ) Left Arm ( ) Right Leg ( ) Left Leg ( ) Neck ( ) Base of Skull
( ) Ribs ( ) Shoulders

Cannot lift: ( ) Light ( ) Moderate ( ) Heavy ( ) Repetitive

OTHER _____

Since the time this (these) complaints(s) began, what, if anything, have you tried that **did not** work?

_____

Has the problem interrupted your sleep? ( ) Yes / ( ) No How: _____

List any doctors or therapists that you have seen for this complaint:

1._____ Specialty _____

2._____ Speciality_____

3._____ Speciality_____

List any operations that you've had and approximate dates:

1._____ Date_____ Dr._____

2._____ Date_____ Dr._____

3._____ Date_____ Dr._____

4._____ Date_____ Dr._____

Are you allergic to any medications? Please list _____

_____

Are you taking any medications? Please list_____

Please complete the inform on the opposite side. Thank You!

Patient Signature_____ Date _____

GENERAL SYMPTOMS

- ❑ Headache
- ❑ Fever
- ❑ Chills
- ❑ Night Sweats
- ❑ Fainting
- ❑ Dizziness
- ❑ Convulsions
- ❑ Loss of Sleep
- ❑ Fatigue
- ❑ Nervousness
- ❑ Loss of Weight
- ❑ Allergy (What)
- ❑ Wheezing
- ❑ Neuralgia
- ❑ Difficult Sleeping
- ❑ Numbness in Legs
  ❑ L ❑ R
- ❑ Numbness in Arms
  ❑ L ❑ R

CARDIO-VASCULAR

- ❑ Rapid Heart
- ❑ Slow Heart
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Pain over Heart
- ❑ Previous Heart Trouble
- ❑ Swelling of Ankles
- ❑ Poor Circulation
- ❑ Varicose Veins
- ❑ Strokes

GASTRO-INTESTINAL

- ❑ Poor Appetite
- ❑ Poor Digestion
- ❑ Excessive Hunger
- ❑ Belching Gas
- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting Blood
- ❑ Pain Over Stomach
- ❑ Constipation
- ❑ Diarrhea
- ❑ Colon Trouble
- ❑ Hemorrhoids (Piles)
- ❑ Liver Trouble
- ❑ Jaundice
- ❑ Gall Bladder Trouble
- ❑ Hiatal Hernia

MUSCLE & JOINTS

- ❑ Shoulder Pain
- ❑ Weakness
- ❑ Twitching
- ❑ Stiff Neck
- ❑ Backache
- ❑ Swollen Joints
- ❑ Tremors
- ❑ Foot Trouble
- ❑ Painful Tail Bones
- ❑ Pain Between Shoulders
- ❑ Hernia
- ❑ Spinal Curvature
- ❑ Growing Pains
- ❑ Faulty Posture
- ❑ Bursitis
- ❑ Neck Pain
- ❑ Knee Pain

SKIN

- ❑ Skin Eruptions
- ❑ Itching
- ❑ Bruising
- ❑ Dryness
- ❑ Boils
- ❑ Sensitive Skin
- ❑ Hives or Allergy
- ❑ Eczema

EYE, EAR, NOSE, THROAT

- ❑ Poor Vision
- ❑ Crossed Eyes
- ❑ Pain in Eyes
- ❑ Deafness
- ❑ Earache
- ❑ Ear Noises
- ❑ Ear Discharge
- ❑ Nasal Obstruction
- ❑ Nose Bleeds
- ❑ Sore Throat
- ❑ Hoarseness
- ❑ Hay Fever
- ❑ Asthma
- ❑ Frequent Colds
- ❑ Enlarged Thyroid
- ❑ Tonsillitis
- ❑ Sinus Trouble

RESPIRATORY

- ❑ Chronic Cough
- ❑ Spitting Blood
- ❑ Spitting Phlegm
- ❑ Chest Pain
- ❑ Difficulty Breathing

GENITOR URINARY

- ❑ Frequent Urination
- ❑ Painful Urination
- ❑ Blood in Urine
- ❑ Kidney Infection
- ❑ Bed Wetting
- ❑ Inability to Control Urine
- ❑ Prostate Trouble

FOR WOMEN ONLY

- ❑ Painful Periods
- ❑ Excessive Flow
- ❑ Irregular Cycles
- ❑ Hot Flashes
- ❑ Cramps
- ❑ Miscarriage
- ❑ Vaginal Discharge
- ❑ Pregnant at this time
  ❑ Yes ❑ No
  Due Date _____

Do you Smoke: ( ) Yes / ( ) No Amount per day

Drink: ( ) Yes / ( ) No ( ) Light ( ) Medium ( ) Heavy

Exercise: ( ) Never ( ) Sometimes ( ) Frequently ( ) Regularly

Patient's Signature _____ Date _____

QUADRUPLE VISUAL ANALOGUE SCALE

Name _____ Number _____ Date _____

INSTRUCTIONS: Please circle the number that best describes the question being asked.

NOTE: If you have more than one complaint, please answer each question for each Individual complaint and indicate which score is for which complaint.

EXAMPLE:

HEADACHE NECK LOW BACK

0 1 (2) 3 (4) 5 6 7 8 (9) 10

1. **What is your pain RIGHT NOW?**

0 1 2 3 4 5 6 7 8 9 10

2. **What is your TYPICAL or AVERAGE pain?**

0 1 2 3 4 5 6 7 8 9 10

3. **What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?**

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

4. **What is your pain AT ITS WORST (How close to "10" does your pain get at its worst)?**

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worst? _____%

Reference: Thomeé R., Grimby G., Wright B.D., Linacre J.M. (1995) Rasch analysis of Visual Analog Scale. *Scandinavian Journal of Rehabilitation Medicine* 27, 145-151.

HEADACHE DISABILITY INDEX

NAME: _____ DATE: _____ AGE: ____ SCORES TOTAL: ____; E____; F____
(100) (52) (48)

INSTRUCTIONS: Please CIRCLE the correct response:

1. I have headache: [1] 1 per month [2] more than but less than 4 per month [3] more than one per week.
2. My headache is: [1] mild [2] moderate [3] severe

INSTRUCTIONS: ***PLEASE READ CAREFULLY:*** The purpose of the scale is to identify difficulties that you may be experiencing because of your headache. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each item as it pertains to your headache only.

	YES	SOMETIMES	NO
E1. Because of my headaches I feel handicapped.	☐	☐	☐
F2. Because of my headaches I feel restricted in performing my routine daily activities.	☐	☐	☐
E3. No one understands the effect my headaches have on my life.	☐	☐	☐
F4. I restrict my recreational activities (e.g. sports, hobbies) because of my headaches.	☐	☐	☐
E5. My headaches make me angry.	☐	☐	☐
E6. Sometimes I feel that I am going to lose control because of my headaches	☐	☐	☐
F7. Because of my headaches I am less likely to socialize.	☐	☐	☐
E8. My spouse/significant other, or family and friends have no idea what I am going through because of my headaches.	☐	☐	☐
E9. My headaches are so bad that I feel I am going to go insane.	☐	☐	☐
E10. My outlook on the world is affected by my headaches.	☐	☐	☐
E11. I am afraid to go outside when I feel a headache is starting.	☐	☐	☐
E12. I feel desperate because of my headaches.	☐	☐	☐
F13. I am concerned that I am paying penalties at work or at home because of my headaches.	☐	☐	☐
E14. My headaches place stress on my relationships with family or friends.	☐	☐	☐
F15. I avoid being around people when I have a headache.	☐	☐	☐
F16. I believe my headaches are making it difficult for me to achieve my goals in life.	☐	☐	☐
F17. I am unable to think clearly because of my headaches.	☐	☐	☐
F18. I get tense (e.g. muscle tension) because of my headaches.	☐	☐	☐
F19. I do not enjoy social gatherings because of my headaches.	☐	☐	☐
E20. I feel irritable because of my headaches.	☐	☐	☐
F21. I avoid traveling because of my headaches.	☐	☐	☐
E22. My headaches make me feel confused.	☐	☐	☐
E23. My headaches make me feel frustrated.	☐	☐	☐
F24. I find it difficult to read because of my headaches.	☐	☐	☐
F25. I find it difficult to focus my attention away from my headaches and on other things.	☐	☐	☐

Reference: Jacobson Gary P., Ramadan NM, et al., The Henry Ford Hospital Headache Disability Inventory (HDI). Neurology 1994; 44:837-842

Patient's Name_____ Number_____ Date_____

NECK DISABILITY INDEX

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

Section 5-Headaches

☐ I have no headaches at all.
☐ I have slight headaches which come infrequently.
☐ I have slight headaches which come frequently.
☐ I have moderate headaches which come infrequently.
☐ I have severe headaches which come frequently.
☐ I have headaches almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered a significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____%ADL_____

Section 6 – Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty in concentrating when I want to.
☐ I have a lot of difficulty in concentrating when I want to.
☐ I have a great deal of difficulty in concentrating when I want to.
☐ I cannot concentrate at all.

Section 7—Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

Section 8 – Driving

☐ I drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive my car at all because of severe pain in my neck.
☐ I can't drive my car at all.

Section 9 – Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr. sleepless).
☐ My sleep is moderately disturbed (1-2 hrs. sleepless).
☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
☐ My sleep is greatly disturbed (3-4 hrs. sleepless).
☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.

Comments_____ %ADL

Reference: Vernon, Mior. JMPT 1991; 14(7): 409-15

FORM 501

SHOULDER PAIN SCORE

Name _____ Number _____ Date _____

	None	Light	Average	Severe
Pain at rest	☐	☐	☐	☐
Pain in motion	☐	☐	☐	☐
Nightly pain	☐	☐	☐	☐
Sleeping problems caused by pain	☐	☐	☐	☐
Incapability of lying on the painful side	☐	☐	☐	☐

	None	Till halfway the upper arm	Till the elbow	Past the elbow
Degree of radiation	☐	☐	☐	☐

Pain Scale:

Indicate on the line below the number between 0 and 100 that best describes your pain.

No pain is 0 ⟶ Unbearable pain is 100

Reference: Winters J. C., Sobel J. S., Gronier K. H., Arendxen J.H., Meyboorn-De Jong B. A Shoulder Pain Score: A Comprehensive Questionnaire for Assessing Pain n Patients with Shoulder Complaints. Scand J Rehab Med 28:163-167. 1996

LOW BACK PAIN DISABILITY QUESTIONNAIRE
(ROLAND-MORRIS)

Name _____ Number _____ Date _____

SCORE: _____

When your back hurts, you may find it difficult to do some of the things you normally do.
Mark only the sentences that describe you today.

- ☐ I stay at home most of the time because of my back.
- ☐ I change position frequently to try and get my back comfortable.
- ☐ I walk more slowly than usual because of my back.
- ☐ Because of my back, I am not doing any jobs that I usually do around the house.
- ☐ Because of my back, I use a handrail to get upstairs.
- ☐ Because of my back, I lie down to rest more often.
- ☐ Because of my back, I have to hold on to something to get out of an easy chair.
- ☐ Because of my back, I try to get other people to do things for me.
- ☐ I get dressed more slowly than usual because of my back.
- ☐ I stand up only for short periods of time because of my back.
- ☐ Because of my back, I try not to bend or kneel down.
- ☐ I find it difficult to get out of a chair because of my back.
- ☐ My back is painful almost all of the time.
- ☐ I find it difficult to turn over in bed because of my back.
- ☐ My appetite is not very good because of my back pain.
- ☐ I have trouble putting on my socks (or stockings) because of pain in my back.
- ☐ I sleep less well because of my back.
- ☐ Because of back pain, I get dressed with help from someone else.
- ☐ I sit down for most of the day because of my back.
- ☐ I avoid heavy jobs around the house because of my back.
- ☐ Because of back pain, I am more irritable and bad tempered with people than usual.
- ☐ Because of my back pain, I go upstairs more slowly than usual.
- ☐ I stay in bed most of the time because of my back.

Reference: Roland, Morris. A Study of the Natural History of Back Pain Part 1: Development of a Reliable and Sensitive Measure of Disability in Low-Back Pain. Spine 1983; 8(2): 141-144

Patient's Name _____ Number _____ Date _____

Low Back Disability Questionnaire (Revised Oswestry)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1- Pain Intensity

- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe
- ☐ The pain is severe and does not vary much.

Section 2- Personal Care (Washing, Dressing, Etc.)

- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increases the pain, but I manage not to change my way of doing it.
- ☐ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing or dressing without help.

Section 3- Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights, at the most.

Section 4- Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a cane or on crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5- Sitting

- ☐ I can sit in any chair as long as I like without pain.
- ☐ I can sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting for more than 1 hour.
- ☐ Pain prevents me from sitting for more than ½ hour.
- ☐ Pain prevents me from sitting for more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

Section 6- Standing

- ☐ I can stand as long as I want without pain.
- ☐ I have some pain while standing, but it does not increase with time.
- ☐ Cannot stand for more than 1 hour without increasing pain.
- ☐ I cannot stand for more than 30 minutes without increasing pain.
- ☐ I cannot stand for more than 10 minutes without increasing pain.
- ☐ I avoid standing, because it increases the pain straight away.

Section 7- Sleeping

- ☐ I get no pain in bed.
- ☐ I get pain in bed, but it does not prevent me from sleeping well.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-quarter.
- ☐ Because of pain, my normal night's sleep is reduced by less than one-half.
- ☐ Because of pain, my normal night's sleep is reduced by less than three-quarters.
- ☐ Pain prevents me from sleeping at all.

Section 8- Social Life

- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of pain.

Section 9- Traveling

- ☐ I get no pain while traveling.
- ☐ I get some pain while traveling, but none of my usual forms of travel make it any worse.
- ☐ I get extra pain while traveling, but it does not compel me to seek alternative from of travel.
- ☐ I get extra pain while traveling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

Section 10- Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates, but overall is definitely getting better.
- ☐ My pain seems to be getting better, but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Loss of Enjoyment

Include all areas which you have had to reduce the time you are capable of experiencing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking, or other restrictions which affect your participation in any of the following areas.

Are there areas of your life which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision?

*Duties you are unable to perform*_____

*Reason for difficulty (how long does it last)*_____

WORK (i.e. you enjoy standing at the board teaching, but cannot because you have too much pain in the arm. It is occurring every day for 4 weeks.)

*Duties you are unable to perform*_____

*Reason for difficulty (how long does it last)*_____

STUDIES/SCHOOL (i.e. you would normally play with your friends at lunch time, but now you cannot because you have too much back pain. It occurs every day for 4 weeks.)

*Duties you are unable to perform*_____

*Reason for difficulty (how long does it last)*_____

HOBBIES of any kind: Please include if you had to reduce the participation or time associated with this activity because you are experiencing any symptoms. (For example: can only jog 1mile versus 2, or socializing for a couple of hours versus the entire evening, postponing vacations, decreasing the amount of times you go out for dinner 1 time every 2 weeks versus 1 time a week)

West Georgia Spine Center
210 South Street
Carrollton, Georgia 30117
770-834-6669

Patient Name _____ **Date**_____

Duties Under Duress

Please include those duties/responsibilities which require that you reduce the time you are capable of performing them. Include all instances where you have received lifting, stretching, bending, sitting, standing, walking, or other restrictions which affect your performance.

Domestic Duties

Examples (List All)	Reason for difficulty	Duration
Vacuuming		
Mopping		
Taking care of children		
Dishes		
Dusting		
Laundry		
Preparing meals		
Other		

Household Duties

Examples (List All)	Reason for difficulty	Duration
Mowing/Yard Work		
Driving		
Shopping		
Taking out trash		
Other		