Name: _____ **Date: _____**

Major Activity's of Daily Living

Using the scale below please number the following activities.

0 1 2 3 4 5 6 7 8 9 10

Unable to perform activity Able to perform

___Walking
___Sitting
___Sleeping
___Standing
___Activities with Children
___Work
___Relaxing
___Gardening
___Driving
___Heavy chores
___Bending/lifting
___Stretching
___Going out with friends
___Irritability
___Dressing/bathing
___Reading
___Concentration
___Memory problems
___Erectile dysfunction

Please answer the following questions carefully and answer each one honestly:
check YES or NO

1. Has your doctor ever said that you have a heart conditions and that you should only do physical activity recommended by a doctor? YES NO
2. Do you feel pain in your chest when you were not doing physical activity? YES NO
3. In the past month, have you had chest pain when you were not doing physical activity? YES NO
4. Do you lose your balance because of dizziness or do you ever lose consciousness? YES NO
5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity? YES NO
6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition? YES NO
7. Do you know of any other reason why you should not do physical activity? YES NO

_____

_____