

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Activities, & School (p. 1 of 2)

Patient _____ Date _____ Date of Injury _____

Initial Update

Please check all that apply to your EXERCISE & SPORTS Activity because of the accident.

- | | |
|-----------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> My exercise was affected by this crash | <input type="checkbox"/> I have gained _____ pounds since the accident |
| <input type="checkbox"/> I go to the gym & work out in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I no longer go to the gym to work out | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I run but in pain | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I no longer run | <input type="checkbox"/> I had to quit my _____ team after the accident |
| <input type="checkbox"/> I take walks & have pain while walking | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I no longer take walks | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I used to make income at sports | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I have lost sports income since crash | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> I am an amateur athlete | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> I am a professional athlete | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I don't enjoy the sport of _____ anymore |
| <input type="checkbox"/> _____ | <input type="checkbox"/> I didn't enjoy the sport of _____ for _____ weeks |

Please check all that apply to your HOBBY Activities because of the accident.

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|---------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> My hobbies were affected by accident | <input type="checkbox"/> Hobby #3 _____ |
| <input type="checkbox"/> Hobby #1 _____ | <input type="checkbox"/> I can't do hobby #3 anymore |
| <input type="checkbox"/> I can't do hobby #1 anymore | <input type="checkbox"/> I do hobby #3 but in pain |
| <input type="checkbox"/> I do hobby #1 but in pain | <input type="checkbox"/> I have lost money from not doing #3 |
| <input type="checkbox"/> I have lost money from not doing #1 | <input type="checkbox"/> I didn't do hobby #3 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #1 for _____ weeks | <input type="checkbox"/> Hobby #4 _____ |
| <input type="checkbox"/> Hobby #2 _____ | <input type="checkbox"/> I can't do hobby #4 anymore |
| <input type="checkbox"/> I can't do hobby #2 anymore | <input type="checkbox"/> I do hobby #4 but in pain |
| <input type="checkbox"/> I do hobby #2 but in pain | <input type="checkbox"/> I have lost money from not doing #4 |
| <input type="checkbox"/> I have lost money from not doing #2 | <input type="checkbox"/> I didn't do hobby #4 for _____ weeks |
| <input type="checkbox"/> I didn't do hobby #2 for _____ weeks | <input type="checkbox"/> _____ |

Please check all that apply to your TRAVEL Activities because of the accident.

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|-------------------------------------------------------------------|--------------------------------------------------------------------------------|
| <input type="checkbox"/> Business travel was affected by crash | <input type="checkbox"/> Travel Plan #1 _____ |
| <input type="checkbox"/> Pleasure travel was affected by crash | <input type="checkbox"/> I did not go on travel plan #1 |
| <input type="checkbox"/> I hurt driving in my own car | <input type="checkbox"/> I went, but did not enjoy #1 as much |
| <input type="checkbox"/> I am in too much pain to drive | <input type="checkbox"/> I went and the accident had no effect on #1 |
| <input type="checkbox"/> I hurt when a passenger in a car | <input type="checkbox"/> Travel Plan #2 _____ |
| <input type="checkbox"/> I am in too much pain to sit in a car | <input type="checkbox"/> I did not go on travel plan #2 |
| <input type="checkbox"/> I have anxiety when I'm in a car | <input type="checkbox"/> I went, but did not enjoy #2 as much |
| <input type="checkbox"/> I hurt when I'm on an airplane | <input type="checkbox"/> I went and the accident had no effect on #2 |
| <input type="checkbox"/> I am in too much pain to travel by plane | <input type="checkbox"/> I missed time with my family/friends b/c can't travel |

Loss of Enjoyment of Sports, Hobbies, Travel, Daily Living, & School (p. 2 of 2)

Patient _____ Date _____ Date of Injury _____

Initial Update

Please check all the DAILY LIVING Activities that cause you pain because of the accident.

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|-------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Riding in a car |
| <input type="checkbox"/> Putting on pants | <input type="checkbox"/> Opening a jar |
| <input type="checkbox"/> Putting on shoes | <input type="checkbox"/> Lifting a pan when cooking |
| <input type="checkbox"/> Tying my shoes | <input type="checkbox"/> Closing the trunk on my car |
| <input type="checkbox"/> Putting on shirt | <input type="checkbox"/> Opening the garage door |
| <input type="checkbox"/> Drying my hair | <input type="checkbox"/> Using my home computer |
| <input type="checkbox"/> Combing my hair | <input type="checkbox"/> Climbing stairs |
| <input type="checkbox"/> Washing my hair | <input type="checkbox"/> Going down stairs |
| <input type="checkbox"/> Taking a shower | <input type="checkbox"/> Sexual activity |
| <input type="checkbox"/> Taking a bath | <input type="checkbox"/> Turning my head to left or right |
| <input type="checkbox"/> Leaning forward | <input type="checkbox"/> Holding my head up all day |
| <input type="checkbox"/> Laying in bed | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Sitting in my favorite chair | <input type="checkbox"/> I have pain sitting & doing nothing |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Talking on the phone |
| <input type="checkbox"/> Going out with my friends | <input type="checkbox"/> Reading |
| <input type="checkbox"/> Sitting in a restaurant | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Shopping | <input type="checkbox"/> Opening doors |
| <input type="checkbox"/> Driving to/from work | <input type="checkbox"/> Drying with a towel after a bath or shower |
| <input type="checkbox"/> Sitting in Church | <input type="checkbox"/> Life has become a chore just to do normal things |
| <input type="checkbox"/> Playing with my children | <input type="checkbox"/> It is depressing to live like this |
| <input type="checkbox"/> Caring for my children | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Bending at the waist | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Sitting in a movie theater | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Eating | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Stooping | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Squatting down | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Kneeling | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Brushing my teeth | <input type="checkbox"/> _____ |

Please check all that apply to your SCHOOL & EDUCATION Activities because of the accident.

- | | |
|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| <input type="checkbox"/> School was affected by the accident | <input type="checkbox"/> I have pain carrying my school books |
| <input type="checkbox"/> I am a student at _____ | <input type="checkbox"/> I hurt sitting in class more than _____ minutes |
| <input type="checkbox"/> I am in the _____ year/grade | <input type="checkbox"/> My neck hurts when I look down to read |
| <input type="checkbox"/> I was <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn as quickly as before the crash |
| <input type="checkbox"/> I am now <input type="checkbox"/> full time <input type="checkbox"/> part time | <input type="checkbox"/> I don't learn things as well as before the crash |
| <input type="checkbox"/> I had to take fewer classes b/c of crash | <input type="checkbox"/> I have difficulty concentrating in class |
| <input type="checkbox"/> I missed _____ days of school | <input type="checkbox"/> It takes much longer to study/do my homework |
| <input type="checkbox"/> I had to drop out of school b/c of crash | <input type="checkbox"/> _____ |
| <input type="checkbox"/> My grades are lower since the crash | <input type="checkbox"/> _____ |

Signature of Patient _____

Date _____