

## 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.**

- |   |   |
|---|---|
| <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.**

- |   |  |
|---|--|
| <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*.**

- |   |   |
|---|---|
| <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