

Clinic Name: Sunrise Chiropractic LLC

Doctor's Name: Dr. Beth L. Davis, D.C.

Patient's Name: _____

Date: _____

Duties Under Duress Summary

Complete the following summary as it relates to your living and work duties and how the injury(s) are affecting your performance. List the day to day living duties which are painful or difficult for you to perform as a result of the injuries you sustained in the motor vehicle collision. 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.

Work **Reason for the difficulty** **Duration**

Job Description: _____

Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

Studies/School **Reason for the difficulty** **Duration**

Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

Domestic Duties **Reason for the difficulty** **Duration**

Vacuuming	Increased Pain	_____
Taking Care of Kids	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties **Reason for the difficulty** **Duration**

Yardwork	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

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Loss of Enjoyment Summary

Complete the following summary as it relates to your lifestyle, work environment and activities which you normally would be enjoying, but are currently not enjoying, as a result of the motor vehicle collision. 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:

Work **Reason for the difficulty** **Duration**

Job Description: _____

Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Other: _____	Increased Pain	_____

Studies/School **Reason for the difficulty** **Duration**

Lifting	Increased Pain	_____
Bending	Increased Pain	_____
Sitting	Increased Pain	_____
Walking	Increased Pain	_____
Computer Duties	Increased Pain	_____
Studying	Increased Pain	_____
Other: _____	Increased Pain	_____

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Loss of Enjoyment

Domestic Duties	Reason for the difficulty	Duration
Vacuuming	Increased Pain	_____
Taking Care of Kids	Increased Anxiety	_____
Cleaning	Increased Pain	_____
Preparing Meals	Increased Pain	_____
Other: _____	Increased Pain	_____

Household Duties	Reason for the difficulty	Duration
Yardwork	Increased Pain	_____
Transportation	Increased Anxiety	_____
Shopping	Increased Pain	_____
Taking Out Trash	Increased Pain	_____
Other: _____	Increased Pain	_____

Sports	Reason for the difficulty	Duration
Social	_____	_____
Competitive	_____	_____
Regional	_____	_____
Other:	_____	_____