

**PATIENT DAILY ACTIVITY SCHEDULE**  
**(Subjective Functional Capacity)**

NAME \_\_\_\_\_

DATE \_\_\_\_\_

Please circle the one best response for each activity described below:

**Activities of Daily Living (bathing, dressing, feeding self, toilet)**

1. Need some assistance
2. Slight difficulty
3. Minimal difficulty
4. No problem

**Laundry**

1. Unable
2. Occasionally
3. Regularly in small steps or with help
4. Regularly without help

**Cooking**

1. Unable
2. Take-out, breakfast, or simple lunch only
3. Simple microwave or crockpot meal
4. Regular meals

**Housekeeping**

1. Unable
2. Light dusting, straighten up
3. Regular housekeeping in small steps or with help
4. Regular

**Grocery Shopping**

1. Unable
2. Occasional (once or twice per month)
3. Frequent, but with assistance
4. No problem

**Social Activities (church, temple, family and friends)**

1. Unable
2. Infrequently
3. Occasionally (once or twice per month)
4. Frequently (weekly or more often)

**Driving**

1. Unable
2. Very limited
3. Cautious, local trips
4. Distant trips or traffic

**Errands or Light Chores (examples: post office, drop off a child)**

1. None
2. 0-1 per day
3. 2-3 per day
4. No or few restrictions

Score: \_\_\_\_\_