

Household & Domestic: Duties Under Duress & Loss of Enjoyment

Patient _____ Date of Accident _____

Describe how the accident has affected your household duties outside the home (i.e. Mowing, gardening, yardwork, house painting, transporting family, shopping, taking out trash etc.) And your domestic duties inside the home (i.e. Vacuuming, cooking, picking up children, caring for children, dusting, cleaning bathrooms, laundry, washing windows/mirrors, etc.)

Duty _____

- I can only do this _____ minutes at a time since the accident
- I have been limited because I had trouble lifting bending standing walking
- I have had to take prescription over-the-counter medications to do this
- I had to do this because I have no other help because I care for the children
- I have experienced the following problems when I do this activity:
 - Range of motion/movements restricted in my body
 - Pain in my _____
 - Headaches Muscle Spasms Dizziness Visual Disturbance
 - Sleep Disruption/Tired/Fatigue/Dozing of/Must rest for a while
 - Radiating pain into my _____
 - Anxiety or depression TMJ/jaw pain or clicking
 - It has taken me longer to do this activity than before the accident

Duty _____

- I have been able to do this _____ minutes at a time since the accident
- I have been limited because I had trouble lifting bending standing walking
- I have had to take prescription over-the-counter medications to do this
- I had to do this because I have no other help because I care for the children
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Signature of patient

Date completed