Patient Name: _____ Date: ___/_____/20___

Duties Under Duress Summary

Complete the following questionnaire as it relates to how your injury(s) affect your performance of your living and work duties. Place a check in front of 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. Then check mark the appropriate box designating reason for difficulty. Include those duties/responsibilities which require that you reduce the time you are capable of performing them.

Job description: _____

N/A	Work	Reason for the difficulty
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Sitting	□ Increased Pain □ Restricted movement □ Weakness
_____	Walking	□ Increased Pain □ Restricted movement □ Weakness
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain □ Restricted movement □ Weakness

N/A	Studies/School	Reason for the difficulty
_____	Lifting	□ Increased Pain □ Restricted movement □ Weakness
_____	Bending	□ Increased Pain □ Restricted movement □ Weakness
_____	Sitting	□ Increased Pain □ Restricted movement □ Weakness
_____	Walking	□ Increased Pain □ Restricted movement □ Weakness
_____	Computer duties	□ Increased Pain □ Restricted movement □ Fatigue
_____	Studying	□ Increased Pain □ Restricted movement □ Fatigue
Other: _____		□ Increased Pain □ Restricted movement □ Weakness

N/A	Domestic Duties	Reason for the difficulty
_____	Vacuuming	□ Increased Pain □ Restricted movement □ Fatigue
_____	Taking care of kids	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Cleaning	□ Increased Pain □ Restricted movement □ Fatigue
_____	Preparing Meals	□ Increased Pain □ Restricted movement □ Fatigue
_____	Other: _____	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue

N/A	Household Duties	Reason for the difficulty
_____	Yardwork	□ Increased Pain □ Restricted movement □ Fatigue
_____	Transportation	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Shopping	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue
_____	Taking out trash	□ Increased Pain □ Restricted movement □ Weakness
_____	Other: _____	□ Increased Pain/Anxiety □ Restricted movement □ Fatigue