

## Duties Performed Under Duress at Work and Home

Patient name \_\_\_\_\_ Date of Injury \_\_\_\_\_ Today's Date \_\_\_\_\_

Initial  Update

### Please check all that apply to your WORK because of the accident

- |   |  |
|---|--|
| <input type="checkbox"/> I go to work but work in pain            | <input type="checkbox"/> I work in pain because I have bills to pay        |
| <input type="checkbox"/> I limit my work activities               | <input type="checkbox"/> I can't take time off because I would lose my job |
| <input type="checkbox"/> Bending at work hurts                    | <input type="checkbox"/> I keep working so I don't lose status at company  |
| <input type="checkbox"/> Stooping at work hurts                   | <input type="checkbox"/> My business would fail if I took time off         |
| <input type="checkbox"/> Sitting at work hurts                    | <input type="checkbox"/> I believe in working even when I'm in pain        |
| <input type="checkbox"/> Using the computer at work hurts         | <input type="checkbox"/> I feel obligated to work even though I'm in pain  |
| <input type="checkbox"/> Pushing at work hurts                    | <input type="checkbox"/> My business would lose money if I took time off   |
| <input type="checkbox"/> Kneeling at work hurts                   | <input type="checkbox"/> My work is not as good as it was before accident  |
| <input type="checkbox"/> I have lost status in my company         | <input type="checkbox"/> My boss reprimanded me for poor performance       |
| <input type="checkbox"/> I have lost job security                 | <input type="checkbox"/> I got a different job within the same company     |
| <input type="checkbox"/> I didn't get a promotion                 | <input type="checkbox"/> I got a different job in another company          |
| <input type="checkbox"/> I don't enjoy work as much as before     | <input type="checkbox"/> I make less money than before the accident        |
| <input type="checkbox"/> I doze off at work                       | <input type="checkbox"/> I cannot do the same work/job as before accident  |
| <input type="checkbox"/> I take unpaid time off work to go to Dr. | <input type="checkbox"/> I can't concentrate as well at work               |
| <input type="checkbox"/> I daydream at work more than before      | <input type="checkbox"/> I take paid time off to go to Dr.                 |
| <input type="checkbox"/> I feel tired at work                     | <input type="checkbox"/> I make mistakes at work I didn't use to           |
| <input type="checkbox"/> _____                                    | <input type="checkbox"/> I hide my poor work performance from my boss      |
| <input type="checkbox"/> _____                                    | <input type="checkbox"/> _____   |
|   | <input type="checkbox"/> _____   |

### Please check all that apply to your HOME/DOMESTIC because of the accident

- |   |  |
|---|--|
| <input type="checkbox"/> My house is not as clean now       | <input type="checkbox"/> I cannot take time off because I care for children  |
| <input type="checkbox"/> My yard is not as neat now         | <input type="checkbox"/> I have _____ children ages _____                    |
| <input type="checkbox"/> My garden is not as productive now | <input type="checkbox"/> I had to hire a paid housekeeper                    |
| <input type="checkbox"/> I do yard work, but do it in pain  | <input type="checkbox"/> I asked someone for unpaid housekeeping help        |
| <input type="checkbox"/> I cannot do my normal yard work    | <input type="checkbox"/> I had to hire a paid gardener                       |
| <input type="checkbox"/> I do house work, but do it in pain | <input type="checkbox"/> I asked someone for unpaid yard work help           |
| <input type="checkbox"/> I cannot do my normal house work   | <input type="checkbox"/> Mowing the lawn hurts me                            |
| <input type="checkbox"/> Doing laundry hurts me             | <input type="checkbox"/> I cannot mow the lawn                               |
| <input type="checkbox"/> I cannot do laundry now            | <input type="checkbox"/> Taking out the trash hurts me                       |
| <input type="checkbox"/> Washing dishes hurts me            | <input type="checkbox"/> I cannot take out the trash                         |
| <input type="checkbox"/> I cannot vacuum now                | <input type="checkbox"/> I do not enjoy my gardening/yardwork like I used to |
| <input type="checkbox"/> Cooking hurts me                   | <input type="checkbox"/> I do not enjoy my housework like I used to          |
| <input type="checkbox"/> I cannot cook now                  | <input type="checkbox"/> Gardening hurts me                                  |
| <input type="checkbox"/> Washing the car hurts me           | <input type="checkbox"/> I cannot do my gardening at all since the accident  |
| <input type="checkbox"/> I cannot wash my car               | <input type="checkbox"/> Others living with me do my share of the work now   |
| <input type="checkbox"/> _____                              | <input type="checkbox"/> Others living with me do my share of the yard now   |
| <input type="checkbox"/> _____                              | <input type="checkbox"/> Others living with me do my share of the gardening  |
|   | <input type="checkbox"/> _____   |

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date