

# Activity Status Report

Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Tel. # \_\_\_\_\_

Contact: \_\_\_\_\_ DOI: \_\_\_\_\_ DOS: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Work Status:  Return to Work  With Restrictions  Full Duty  Discharged  
 Unable to Work Due To: \_\_\_\_\_  Not Work Related  
Start Date: \_\_\_\_\_

## Activity Restrictions

### Upper Extremities R L Both

\_\_\_\_ None  
\_\_\_\_ Lifting restriction \_\_\_\_\_  
\_\_\_\_ No overshoulder height movements  
\_\_\_\_ Push/Pull limit \_\_\_\_\_  
\_\_\_\_ No repetitive Use  
\_\_\_\_ Grip \_\_\_\_\_  
\_\_\_\_ Fine manipulation

### Lower Extremities R L Both

\_\_\_\_ None  
\_\_\_\_ No repetitive Use  
\_\_\_\_ No pedal Use  
\_\_\_\_ No squatting, kneeling, crawling  
\_\_\_\_ No ladder climbing  
\_\_\_\_ No stair climbing

### Neck

\_\_\_\_ None  
\_\_\_\_ Twisting restriction \_\_\_\_\_  
\_\_\_\_ Head gear weight maximum \_\_\_\_\_

### Back

\_\_\_\_ None  
\_\_\_\_ Change position every \_\_\_\_ minutes  
\_\_\_\_ Maximum sitting \_\_\_\_\_  
\_\_\_\_ Waist bending \_\_\_\_\_  
\_\_\_\_ Lifting restriction \_\_\_\_\_

### Other

\_\_\_\_ None  
\_\_\_\_ Keep area clean, dry, free from trauma  
\_\_\_\_ Must wear brace/splint  
\_\_\_\_ Must use crutches when up  
\_\_\_\_ Driving \_\_\_\_\_  
\_\_\_\_ Other \_\_\_\_\_

**Follow Up:** **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **With:** \_\_\_\_\_

Referrals: Physical Therapy \_\_\_\_ Occupational Therapy \_\_ Studies: \_\_\_\_\_

Refer To: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Phone #: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_

I understand my diagnosis, activity restrictions, return-to-work status, and the plans for the treatment of my medical problem. I understand my employer will receive a copy of this form.

Patient's Signature: \_\_\_\_\_