Welcome to
The Knee Clinic
at

Lady Lake Family Medicine

John D. Burress, D.O.
Jane Johansson, APRN
352-430-5300

1. **We are glad you have chosen us for your medical care.** We will promise to help provide you with the medical information and services you need in a timely fashion and supportive environment.

2. **Who is Doctor Burress?** He is a third generation Floridian who went to U.C.F. for simultaneous double degrees in biology and psychology. He worked and did research for a neuropsychologist until he was accepted at N.S.U. in Miami where he received his medical degree in 1998. He did his internship near Tampa, FL and his family medicine residency in Orlando at Florida Hospital, one of Florida's largest medical institutions. Just prior to starting this practice he was Medical Director for a corporation that had multiple urgent care facilities in the area.

3. **What is a D.O.?** He/she is a medical doctor just like any M.D., but one who has undergone additional training in muscular-skeletal medicine. Only M.D.'s and D.O.'s are allowed by the state and national government to call themselves doctors and practice all aspects of medicine and surgery.

7. **Who is Jane Johansson, APRN?** Jane Johansson, BA, MSN, APRN-BC grew up in Cinnaminson, NJ, then her family moved to the rural town of New Hartford, Ct. She attended the University of Connecticut, graduated Magna Cum Laude and was elected to the national honor society Phi Beta Kappa with a BA degree in communications/journalism in 1985. Several years later she attended St. Mary's School of Nursing in Waterbury, Ct and earned her RN certification in 1994 and worked in acute care for 18 yrs. Jane then returned to the University of Connecticut and earned a master's degree in nursing and sat for the American Nurses Credentialing Center (ANCC) Acute Care adult/geriatric board certification exam in 2012, which has been renewed every 5 years. Jane continues her passion for knowledge and up to date medical information by completing over 400 hours of continuing medical education every 5 years. Jane has worked in medical oncology/hematology at Yale New Haven Hospital/Smilow Cancer Hospital in Ct. and Florida Cancer Specialists in Lady Lake, Fl. Jane has additional APRN experience in internal medicine, Geriatrics and pain management, all to better serve our patients.

6. **What is an Advanced Nurse Practitioner?** Advanced Practice Registered Nurse (APRN) or Nurse practitioner (NP) is a registered nurse (RN) who is prepared, through advanced education and clinical training, to provide a wide range of preventive and acute health care services to individuals of all ages. NPs complete graduate-level education preparation that leads to a master's or doctoral degree. NPs take health histories and provide complete physical examinations; diagnose and treat many common acute and chronic problems; interpret laboratory results and imaging studies; prescribe and manage medications and other therapies; provide health teaching and supportive counseling with an emphasis on prevention of illness and health maintenance; and refer patients to other health professionals as needed. An NP's practice may also include education, research, and administrative services.

Noteworthy Notes

1. **Time Policy -** We strive to be on time all the time. The nature of medicine is such that issues often come up that need to be dealt with immediately. Please know that we are always aware that your time is important and that your issues will also receive the same attention when needed. If you are late, please be aware that we may have already moved on to the next scheduled patient and we will try to work you back into the schedule, but that may not always be possible.

2. **Charges -** This should not have to be said, but it may relieve your worries in some cases to state at the outset. We will never recommend a test that we don't think you need in some misguided attempt to make money. On the same tact, we will always inform you of necessary tests regardless of your insurance or ability to pay. We may be able to modify tests to help comply with insurance plans but we practice medicine, not economics. If you have a billing question, feel free to contact our billing department.

3. **Labs -** When we recommend outside x-rays, MRIs or other exams, these tests may will incur a separate charge even if we arrange the procedure for you as a courtesy. We have no control over how much laboratories charge for their services. **We do not** get kickbacks or other incentives from any facility we send you to.

4. **Payment -** Payment is due at the time services are rendered. If we accept your insurance we will bill them for you as a courtesy, however the responsibility remains with you for full payment. Ninety days after a correct claim has been sent, all unpaid bills become the patient's guarantor's sole responsibility. In the interest of providing care to all, an affordable payment plan may be arranged.

5. **Other Providers -** If other doctors are involved in your care, it is your responsibility to make the staff aware of any changes that may have occurred since your last visit.

Thank you for choosing
The Knee Clinic
at
Lady Lake Family Medicine
607 Highway 466
Lady Lake, FL 32159
352-430-5300

If you have any questions or concerns, please do not hesitate to contact us.

We look forward to working with you towards your continued good health.

The Knee Clinic at
LADY LAKE FAMILY MEDICINE

John D. Burress, D.O.
Jane Johansson, APRN

PATIENT DEMOGRAPHIC REGISTRATION FORM

Date:_____

PATIENT INFORMATION

Name: _____

_____ _____
PREFIX SUFFIX (I, II, III, JR, SR, etc.)

Date of Birth: _____ Gender: M F SSN:_____/_____/_____

Marital Status:_____ DL#_____ State _____

Phone (H) _____ Phone (W) _____ Ext_____

Phone (Cell)_____ Email: _____

Address: _____
_____
City _____ State _____ Zip Code _____

Is this your permanent address? Y N
If no, please indicate permanent address and phone below:
_____
_____
_____
Phone: _____

Person responsible for Account:_____ Relationship:_____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____
Address: _____ Phone# _____
Policy # _____ Group# _____
Policy Holder _____ Relation to Patient: _____
Policy Holder DOB (if other than patient): _____
Policy Holder Address (if different than patient): _____
_____
Policy Holder Phone # (if different):_____

Patient: _____ DOB _____

ADDITIONAL INSURANCE INFORMATION:

Insurance Company: _____

Address:_____Phone# _____

Policy # _____ Group# _____

Policy Holder:_____ Relation to Patient _____

Policy Holder DOB (if other than patient):_____

Policy Holder Address (if different than patient):_____
_____

ASSIGNMENT and RELEASE:

I certify that I, and/or my dependent(s), have insurance coverage with _____,
(Name of Insurance Company (ies))
and assign directly to Lady Lake Family Medicine, and all its providers, all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above mentioned physicians may use my health care information and may disclose such information to the above named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Relation

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EMERGENCY CONTACT INFORMATION:

Name:_____ _____
LAST *FIRST*

Phone:_____ _____
HOME OR WORK *CELL*

Relationship:_____

Patient Medical History Form

Print Name: _____ Date of Birth: _____

Date: _____ SSN# _____ State of Full-Time Residence: _____

Circle: Single, Married, Divorced, or Widowed. Race: _____ Ethnicity: _____ Language(s): _____

Drug Allergies:_____

Occupation: _____

Please list the reason for today's visit:

1._____

2._____

3._____

Current Medications:

Medication Name Dosage Strength (mg) Directions (take # per day) Prescribed by

Example: Tylenol	500mg	2 tablets once a day in the mornings	Dr. Who

Print Name: _____ Date of Birth: _____

Family History: **F** – Father **M** – Mother **C** – Children **S** – Sister **B** - Brother **FF** – Father's Father **FM** – Father's Mother **MF** – Mother's Father **MM** – Mother's Mother

Alcoholism _____
Asthma _____
Bleeding Disorder _____
Cancer & Type _____
Depression/Anxiety _____
Diabetes _____
Glaucoma _____
Hair Loss _____
Heart Disease _____
High Blood Pressure _____
Kidney Disease _____
Mental Illness _____
Migraines _____
Osteoporosis _____
Seizures/Epilepsy/Convulsions_____
Stroke _____
Thyroid Disease _____
Other _____
Other _____
Other_____

Social History: Smoker____ Former Smoker____ Never Smoked_____ How many years_____
Cigarettes: ___Yes ___No, How many/much per day_____
Smoke for How Many Years _____ (Age started _____ Age Quit _____)
Tobacco: Dip/Snuff/Chew ___Yes ___No, Amount per day _____ (Age started _____ Age Quit _____)
eCigs or Vaporizors ____Yes ____No Other:_____
Recreational Drug Use ____Yes ____No If Yes, please state type _____
Alcohol: ___Yes ___No Type_____ How Much?_____ How often?_____

Please List All Additional Medical Providers & Approximate Date of Last Visit with Them

Family / Primary Care: _____

Cardiologist (heart, vascular): _____

Orthopedic (bones & joints): _____

Chiropractor: _____

Pain Management: _____

Physical Therapy: _____

Home Health:_____

Other: _____

Thank You for Choosing

The Knee Clinic at Lady Lake Family Medicine

Dear Patient:
A new requirement for medical practices is to assess your potential risk for falls. Please complete the following:

FALL RISK ASSESSMENT

Have you fallen in the past year?	YES	NO
Do you lose your balance when standing	YES	NO
Do you lose balance when you initially get up after sitting?	YES	NO
Do you get dizzy, faint or have seizures?	YES	NO
Does it take you more than one try to get up out of a chair or out of bed?	YES	NO
Do you trip over your own feet or objects on the floor?	YES	NO
Do you take corners too sharp; bump into corners or door frames?	YES	NO
Do you use a walker, cane or need assistance to get around?	YES	NO
Do you lose your balance, feel unsteady or stagger when walking?	YES	NO
Have you had a recent loss of or decrease in vision or hearing?	YES	NO
Do you have numbness or loss of sensation in your feet or legs?	YES	NO
Have you experienced a stroke, accident or any other health problems that may have affected your balance?	YES	NO

If you have answered YES to one or more questions, you may have a balance problem. If you are concerned about falling you should speak with your physician.

Patient Name (Printed):_____ DOB: _____

Patient Signature:_____ Date:_____

The Knee Clinic at
LADY LAKE FAMILY MEDICINE
John D. Burress, D.O.
Jane Johansson, APRN

FINANCIAL POLICY STATEMENTS

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment for your bill is considered part of your treatment. In order to reduce confusion and misunderstanding between you and the practice, we have adopted the following financial policy, which we require you read, agree to, and sign prior to any treatment. If you have any further questions about the policy, please discuss them with our Patient Finance Counselor. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY; THE DOCTOR IS NOT INVOLVED.

- AS A COURTESY, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. IF YOUR INSURANCE COMPANY DOES NOT PAY THE PRACTICE WITHIN 45 DAYS OF FILING, YOU WILL BE RESPONSIBLE FOR FULL PAYMENT.

- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment or coinsurance at the time of service. WE WILL COLLECT THE COPAYMENT OT COINSURANCE WHEN YOU ARRIVE FOR YOUR APPOINTMENT. If your insurance plan denies payment, the remaining balance will be your responsibility.

- If you have insurance coverage with a PLAN THAT WE DO NOT HAVE A PRIOR AGREEMENT, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. THEREFORE, OUR CHARGES FOR YOUR CARE AND TREATMENT ARE DUE AT THE TIME OF SERVICE.

- Unless other arrangements have been made in advance, FULL PAYMENT IS DUE AT THE TIME OF SERVICE. For your convenience, we will accept CASH, CHECK, VISA, MASTERCARD, DISCOVER and DEBIT CARDS.

- All health plans are not the same and do not cover the same services. In the event your health plan determines a SERVICE or SERVICES ARE NOT COVERED, you will be responsible for the complete charge. PAYMENT IS DUE AT THE TIME OF SERVICE.

- For all services rendered to minor patients, the parent or legal guardian who is accompanying the minor patient is responsible for payment at the time of service.

- Ancillary services provided by this practice (ie: ultrasound, injections, labs) may be subject to additional financial policy statements.

- In order to provide the best possible service and availability to all of our patients, please call us as early as possible if you need to cancel or reschedule your appointment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms can be amended from time to time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____

Signature of Co-Responsible Party

_____

Please print the name of the Patient

The Knee Clinic at
LADY LAKE FAMILY MEDICINE

607 Hwy 466
Lady Lake, FL 32159
352-259-7994

PATIENT HIPAA AUTHORIZATION FORM

The Department of Health and Human Services has established a "Privacy & Security Rule" to help insure that personal health information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain healthcare providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of all your personal health records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. **When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health information and information about treatment, payment, or healthcare operation in order to provide healthcare that is in your best interest.**

There are times you may wish other family members and friends to inquire about your appointments or have access to your medical information. We will not release any information unless you have listed them below. If you wish to allow messages other than just to return our calls on your voicemail, please indicate this also below.

Voicemail: NO_____ Do not leave message other than to "return call"
YES_____ May leave message regarding medical information

List any family members or others you wish to have access to our records, for example, who may call is regarding your condition or call for you. **WE WILL NOT RELEASE INFORMATION TO SPOUSES OR CHILDREN UNLESS THEY ARE LISTED BELOW.** (We will require signed releases by you for anyone wanting access to your records other than insurance companies you have listed on file, your healthcare provider necessary to your care or persons listed below).

Names authorized (by patient) to receive medical information & their relation to patient:

1. _____ Relation:_____
2. _____ Relation:_____
3. _____ Relation:_____
4. _____ Relation:_____

I, _____also understand I may revoke this authorization at any time, and receive a copy of this authorization.

PRINTED NAME:_____ DATE:_____

SIGNATURE:_____

NO SHOW & CANCELLATION POLICY
For The Knee Clinic at
LADY LAKE FAMILY MEDICINE

Patient Name:_____ Date of Birth: _____

Dear Patient,

The Knee Clinic at Lady Lake Family Medicine has instituted a formal policy regarding cancellations and "no shows". A "no show" is defined as a scheduled appointment that the patient does not keep. To help our patients, we will call to confirm your appointment up to two days before your scheduled appointment. Patients are expected to contact our office no later than twenty-four (24) hours in advance if it is necessary to cancel your appointment so this time can be given to someone who is in need of treatment. Every no-show visit will be recorded in your medical record, and the following administrative fees will be assessed to your account:

First Occurrence: Patient will be sent a letter or called. ***No fine assessed***.

Second Occurrence: Patient will be charged a **$50.00 fee**. (*This fee is the patient's responsibility and is not reimbursable by insurance).*

Third Occurrence: Patient will be charged the full price of the scheduled office visit/procedure. (*This fee is the patient's responsibility and is not reimbursable by insurance).* Patient may be discharged from the practice. The decision whether or not to discharge you will be at your doctor's discretion.

Our aim is to open otherwise unused appointments for our patients, not to collect missed appointment fees. If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you may have. We thank you in advance for your cooperation and understanding. By signing below, you acknowledge that you have been presented with the above policy.

_____ _____

Patient Signature Date

_____

Witness

The Knee Clinic at
LADY LAKE FAMILY MEDICINE
RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of, or read, The Knee Clinic at Lady Lake Family Medicine's Notice of Privacy Practices containing a description of the uses and disclosures of my health information, certain restrictions on the use and disclosure of my healthcare information and rights I have regarding my protected health information. I further understand that Lady Lake Family Medicine may update its *Notice of Privacy Practices* at any time and that I may receive an updated copy by requesting a current copy.

_____ _____
Signature of Patient Date

If completed by patient's personal representative, please print and sign below.

_____ _____
Printed Patient Personal Representative Name Relation to Patient

_____ _____
Patient Personal Representative Signature Date

The Knee Clinic at Lady Lake Family Medicine
607 Hwy 466
Lady Lake, FL 32159
352-259-7994

Your Information
Your Rights
Our Responsibilities

Your rights-You have the right to:

- ✔ Get a copy of your electronic medical record
- ✔ Correct your electronic medical record
- ✔ Request confidential communication
- ✔ Ask us to limit the information we share
- ✔ Get a list of those with whom we've shared your information
- ✔ Get a copy of this privacy notice
- ✔ File a complaint if you believe your privacy rights have been violated.

Your Choices- You have choices in the way that we use and share information as we:

- ✔ Tell family and friends about your condition
- ✔ Provide disaster relief
- ✔ Include you in a hospital directory
- ✔ Provide mental health care
- ✔ Market our services and sell your information
- ✔ Raise funds

Our Uses and Disclosure- We may use and share your information as we:

- ✔ Treat you
- ✔ Run our organization
- ✔ Bill for your services
- ✔ Help with public health and safety issues
- ✔ Do research

- ✔ Comply with the law
- ✔ Respond to organ and tissue donation requests
- ✔ Work with a medical examiner or funeral director
- ✔ Address workers' compensation, law enforcement, and other government requests
- ✔ Respond to lawsuits and legal action

The Knee Clinic at
LADY LAKE FAMILY MEDICINE

John D. Burress, D.O.
Jane Johansson, APRN
607 Highway 466 Lady Lake, FL 32159
352-259-7994 FAX 352-259-7992

REQUEST FOR RELEASE OF MEDICAL INFORMATION

(Make sure all information is complete to prevent a delay in release of information)

Patient's Full Name_____DOB_____

Adress:_____

Phone Number:_____ Last 4 digits of Social Security#_____

This will authorize:

_____
_____ ***to release information to***: **Lady Lake Family Medicine**
_____ **607 Hwy 466**
_____ **Lady Lake, FL 32159**

Purpose for Disclosure:_____

Dates of service to release (FROM):_____**(TO):**_____

Medical Information Request

- ▢ Complete Records
- ▢ Laboratory Reports
- ▢ Immunization Record
- ▢ Other _____
  _____
- ▢ Radiology Reports
- ▢ Operative Reports/Discharge Summaries
- ▢ Cardiac Reports

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW

I specifically authorized the release of data and information relating to: **(YOU MUST MARK YES OR NO)**

Yes	**No**	
▢	▢	1. Substance Abuse (alcohol/drug use)
▢	▢	2. Mental Health/Depression (includes psychological testing)
▢	▢	3. HIV-Related Information (AIDS related testing)

I, the undersigned, authorize Lady Lake Family Medicine to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain certain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AID/AIDS-related condition, and/or alcohol/drug abuse. **This authorization does not include permission to release outpatient Psychotherapy Notes. Release of psychotherapy Notes requires a separate authorization.**

This authorization and consent will expire on year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to Lady Lake Family Medicine. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

After my health information is released, my information may be re-disclosed by the recipient and may no longer be protected by law. The recipient of my health information may be charged for the service of releasing medical information. There is no charge to send records directly to my health care provider.

If Authorization is not complete, signed and dated, It may be returned and result in my information not being released until completed.

_____/ _____ _____

Signature of Patient or Legal Guardian | Printed Name | Date

_____ _____

Relationship (if not patient) | Daytime Phone Number | Witness

Osteoarthritis Subjective/HPI

Patient Name: _____ **DOB:** _____

Allergies to Medications/Dyes**:**_____

Chief Complaint:(check all that apply) ☐ Right Knee ☐ Left Knee
☐ Pain ☐ Stiffness ☐ Mobility ☐ Instability

When did problem/pain begin: _____

Precipitating event/injury? □ None □ Running □ Climbing □ A Fall □ Squatting
□ Lifting □ Motor Vehicle Accident □ Lifting □ Other
_____

Pain Level: (0 = no pain 10 = worst pain): **Average** _____ **Worst** _____

What makes pain worse:) (check all that apply)**:** □ Sitting □ Standing □ Walking □ Getting Dressed
□ Going Up Stairs □ Going down stairs or incline □ Carrying > 10 lbs □ Driving
□ Dancing □ Working □ Laying Down □ Jumping □ Kneeling □ Squatting
□ Extending knee straight □ Bending knee

What makes pain better: (check all that apply): □ Aspirin □ NSAIDs (e.g. Advil/Motrin/Aleve) □ Heat
□ Ice □ Rest □ Knee elevation □ Extending the knee □ Bending the knee □
Nothing

Frequency of symptoms:
□ Constant (76 – 100% of the day) □ Frequent (51 – 75% of the day)
□ Occasional (26 – 50% of the day) □ Infrequent (1 – 25% of the day)

Nature of symptoms: (check all that apply)
□ Sharp □ Shooting □ Dull □ Numbness □ Tingling □ Burning □ Radiating □ Throbbing
□ Aching □ Stabbing □ Clicking □ Knee Gives Out □ Locking □ Swelling □ Stiffness

Mechanism of Injury or Pain:
□ Gradual Onset □ Sudden Onset □ Traumatic

I am able to walk:
□ < 5 minutes □ < 10 minutes □ < 15 minutes □ < 30 minutes □ 30 minutes
□ 45 minutes □ One hour □ Only a few steps □ Around the house only

I have tried and failed conservative therapy of at least 90 days e.g. (include dates)
☐ NSAID (anti-inflammatories) (i.e. Aspirin, Advil, Motrin Celebrex)
☐ Acetaminophen (i.e. Tylenol)
☐ Topical Creams (i.e. Diclofenac, Voltaren)
☐ Weight Reduction (If overweight)
☐ Cardiovascular (aerobic) activity, such as: walking, biking, stationary bike, aquatic exercise
☐ Physical Therapy
☐ Occupational Therapy
☐ Participation in self-management programs
☐ Wear of medically directed patellar taping
☐ Thermal agents
☐Walking Aids
☐Resistance exercise

Patient Name:_____ **DOB:** _____ ☐ Right Knee ☐ Left Knee

Surgical History:

□ **Arthroscopic surgery** □ Total knee replacement *Right / Left / Both*

□ **History of previous injections**

Steroid Injections *Right/Left/Both* Date: _____

Hyaluronic Acid Injections *Right/Left/Both* Date:_____

□ **If prior injection, did you get pain relief?** ☐ Yes ☐ No ☐ Partial

Additional Notes: _____

_____

_____

_____

Last Imaging (X-ray/MRI): _____

Patient Signature: _____ **Date**: _____

Discussed/Reviewed by Provider: _____ **Date:** _____

WOMAC Osteoarthritis Index

Name:_____ DOB:_____
Date: _____

Knee: Right Left Initial Index Index at: 3rd 4th 5th Injection 3 Month 6 Month
(Above for office use only)

PAIN:
The following questions concern the amount of pain you are currently experiencing in your knees. Indicate the level of knee pain associated with:

	None	Mild	Moderate	Severe	Extreme
1. Walking on a flat surface					
2. Going up or down stairs					
3. At night, while in bed					
4. Sitting or laying					
5. Standing upright					

STIFFNESS:
The following questions concern the amount of stiffness you have throughout the day:

	None	Mild	Moderate	Severe	Extreme
1. On first awakening in the morning					
2. When first getting out of bed					
3. After sitting, lying or resting later in the day					

PHYSICAL FUNCTION:
The following questions concern your physical function. By this we mean your ability to do tasks and move around yourself. If you use an assistive device, please say what kind here: _____
What degree of difficulty do you have:

	None	Mild	Moderate	Severe	Extreme
1. Descending (going down) stairs					
2. Ascending (going up) stairs					
3. Sitting					
4. Rising from sitting					
5. Standing					
6. Bending to floor					
7. Walking on a flat surface					
8. Getting in/out of car					
9. Going shopping					
10. Putting on socks/stockings					
11. Taking off socks/stockings					
12. Rising from bed					
13. Lying in bed					
14. Getting in/out of bath					
15. Getting on/off toliet					
16. Heavy duties (e.g. mowing lawn)					
17. Light duties (e.g. cleaning/cooking)					