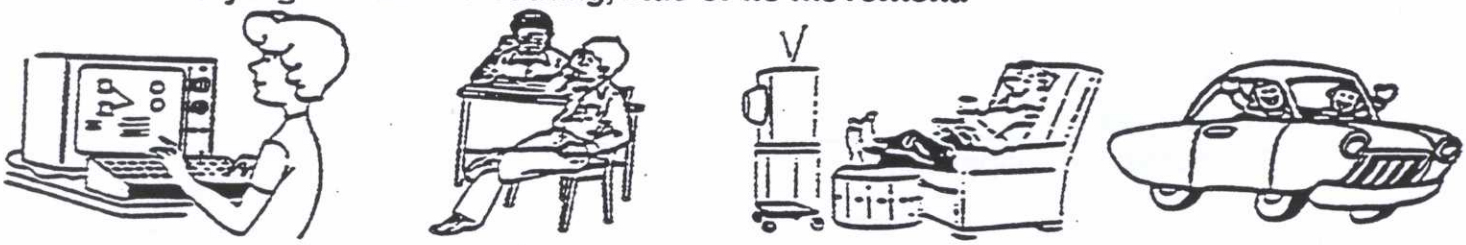
Activities Scale

On the next page is a scale which records the **main** activities you did yesterday. Please be certain to write on the scale the **day of the week** that "yesterday" was.

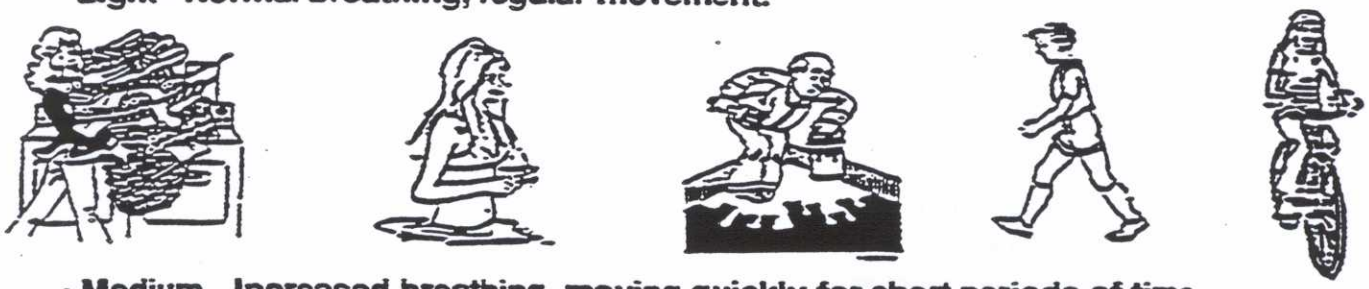
1. For **each** time period write in the **number(s)** of the main activities you actually did in the boxes on the time scale.

2. Then rate how physically **hard** these activities were. Place an "X" on the rating scale to indicate if the activites for each time period were:

- **Very Light - Slow breathing, little or no movement.**



- **Light - Normal breathing, regular movement.**



- **Medium - Increased breathing, moving quickly for short periods of time.**

- **Hard - Hard breathing, moving quickly for 20 minutes or more.**

Please be as accurate as possible but fill out the scale quickly.

Activity Numbers

Eating

1. Meal
2. Snack
3. Cooking

Sleep/Bathing

4. Sleeping
5. Resting
6. Shower/bath

Transportation

7. Ride in car, bus
8. Travel by walking
9. Travel by bike

Work/School

10. Job (list) _____
11. Homework/paperwork
12. House chores (list) _____

Spare Time

13. Watch TV
14. Go to movies/concert
15. Listen to music
16. Talk on phone
17. Hang around
18. Shopping
19. Play video games
20. Other (list) _____

Physical Activities

21. Walk
22. Jog/run
23. Dance (for fun)
24. Aerobic dance
25. Swim (for fun)
26. Swim laps
27. Ride bicycle
28. Lift weights
29. Use skateboard
30. Play organized sport
31. Did individual exercise
32. Did active game outside
33. Other (list) _____

Circle the day of the week that you did these activities

M T W Th F Sa Su

1. Put Activity Numbers in this column.

2. Put an "X" to rate how hard these activities were




		Activity Numbers	Very Light	Light	Medium	Hard
Afternoon	3:00					
	3:30					
	4:00					
	4:30					
Supper	5:00					
	5:30					
	6:00					
	6:30					
Evening	7:00					
	7:30					
	8:00					
	8:30					
	9:00					
	9:30					
Night	10:00					
	10:30					
	11:00					

Date _____ ID Code_____

QUESTIONNAIRE

Your Name _____

Your Birth Date _____

First Name of Your Mother (or other adult who takes care of you)

_____