PATIENT-SPECIFIC FUNCTIONAL SCALE

I am going to ask you to identify up to three important activities that you are having difficulty with or are unable to do as a result of your problem. Today, are there any activities that you are having difficulty with or are unable to do as a result of your problem? Please rate the difficulty you are having on a scale from 0 to 10 where 0 means you are completely unable to perform that activity and 10 means that you are able to perform that activity at the same level as before your injury/problem.

Height__________
Weight__________

	0 Unable to perform	1	2	3	4	5	6	7	8	9	10 No restrictions
Bending:	0	1	2	3	4	5	6	7	8	9	10
Care –Infirm Family:	0	1	2	3	4	5	6	7	8	9	10
Carrying Groceries:	0	1	2	3	4	5	6	7	8	9	10
Change Posn–Sit-Stand:	0	1	2	3	4	5	6	7	8	9	10
Climb Stairs:	0	1	2	3	4	5	6	7	8	9	10
Driving:	0	1	2	3	4	5	6	7	8	9	10
Eating:	0	1	2	3	4	5	6	7	8	9	10
Extended Computer Use:	0	1	2	3	4	5	6	7	8	9	10
Household Chores:	0	1	2	3	4	5	6	7	8	9	10
Kneeling:	0	1	2	3	4	5	6	7	8	9	10
Lift Children:	0	1	2	3	4	5	6	7	8	9	10
Lifting:	0	1	2	3	4	5	6	7	8	9	10
Pet Care:	0	1	2	3	4	5	6	7	8	9	10
Reading (Concentration):	0	1	2	3	4	5	6	7	8	9	10
Self Care–Bathing:	0	1	2	3	4	5	6	7	8	9	10
Self Care–Dressing:	0	1	2	3	4	5	6	7	8	9	10
Self Care–Shaving:	0	1	2	3	4	5	6	7	8	9	10
Sexual Activities:	0	1	2	3	4	5	6	7	8	9	10
Sleep:	0	1	2	3	4	5	6	7	8	9	10
Static Sitting:	0	1	2	3	4	5	6	7	8	9	10
Static Standing:	0	1	2	3	4	5	6	7	8	9	10
Walking:	0	1	2	3	4	5	6	7	8	9	10
Yard Work:	0	1	2	3	4	5	6	7	8	9	10
Other:											
____________________	0	1	2	3	4	5	6	7	8	9	10
____________________	0	1	2	3	4	5	6	7	8	9	10
____________________	0	1	2	3	4	5	6	7	8	9	10

PATIENT SIGNATURE _________________________________ Date ____________________

CURRENT HEALTH CONDITION

Chief complaint (Why you are here today):____

____

____

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT
Use the letters below to indicate the type and location of you sensations right now:
A= Ache B=Burning N=Numbness P=Pins & Needles S=Stabbing O=Other

When did this condition begin? _____/_______/_________
Has it ever occurred before? ☐ Yes ☐ No
When? ____
Is the condition getting worse? ☐ Yes ☐ No
Is the condition: ☐ Auto Related ☐ Work Related
☐ No Injury ☐ Other
Explain: ____

____
Date of Accident: ____
Time of Accident: ____
Complaint/Pain Onset Date: _____________________________
If Work Related:
Have you filed an injury report with your employer? ☐Yes ☐ No
Claim #: ____