

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name: _____ Age: _____ Gender: _____ Number of Visits: _____

Using the key below please circle one answer in each box that indicates your ability to do the following activities;

Key: (0 = unable) (1 = very difficult) (2 = moderately difficult) (3 = minimally difficult) (4 = normal)
(N/A = not applicable to your current condition)

Activity	Score					
1. Sleep normally	0	1	2	3	4	N/A
2. Up and Down Stairs	0	1	2	3	4	N/A
3. Food Prep/Cooking/Eating	0	1	2	3	4	N/A
4. Walking	0	1	2	3	4	N/A
5. Grooming (bath, comb hair, shave, etc)	0	1	2	3	4	N/A
6. Getting up/down from chair or bed	0	1	2	3	4	N/A
7. Dressing – manage normal dressing activities	0	1	2	3	4	N/A
7a: Dressing – Tie Shoes/Button Shirt	0	1	2	3	4	N/A
8. Lifting/Carrying up to 10 pounds	0	1	2	3	4	N/A
9. Sitting for normal periods of time	0	1	2	3	4	N/A
10. Standing for normal periods of time	0	1	2	3	4	N/A
11. Reaching above head or across body	0	1	2	3	4	N/A
12. Leisure/Recreational/Sports Activities	0	1	2	3	4	N/A
13. Squatting down to pick up item	0	1	2	3	4	N/A
14. Running/Jogging	0	1	2	3	4	N/A
15. Driving	0	1	2	3	4	N/A
16. Job Requirements – can do all activities required of my job	0	1	2	3	4	N/A

Pain Scale - Please circle the number that describes the pain you have experienced over the last week with 0 being no pain and 10 the worst imaginable – **WHEN NOT TAKING PAIN MEDICATION.**

0	1	2	3	4	5	6	7	8	9	10
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FOR OFFICE USE ONLY

Group Name/Location: _____ / _____ PT or OT Evaluation or Discharge Date: _____
 Region (use key) _____ Diagnosis (use key) _____
 Therapist Name: _____