This is a functional assessment questionnaire that is important to determine how your current health condition is affecting your daily life. Please fill out this form as accurately as you can.

In the space by each activity, write the number that corresponds with the level of restriction.

(0)-No difficulty, (1)- Mild difficulty, (2)- Moderate difficulty, (3)- Severe difficulty, (4)- Can't Do

Pain level: 0- 10, 0- no pain—10- unbearable pain: Rating: _____

Sleep: _____

Driving a car: _____

Recreation: _____

Lifting 10-25 lbs: _____

50 lbs +: _____

Static standing: _____

Overhead reaching: _____

Pet care: _____

Computer use: _____

Climb stairs: _____

Carry groceries: _____

Household chores: _____

Yard work: _____

Caring for family: _____

Going down stairs: _____

Self Care -Dress, bath, shave, etc.:_____

Job Performance: _____

Lifting 0-10 lbs: _____

Lifting 25+ lbs : _____

Walking: _____

Kneeling (e.g. weed garden) : _____

Changing position from sit to stand: _____

Reading (concentration): _____

Feeding/eating: _____

Sexual activities: _____

Static sitting: _____

Lifting children: _____

Bending to tie/put on shoes: _____

Getting into/out of car: _____