**FUNCTIONAL ASSESSMENT QUESTIONNAIRE**

Eval/Progess/Discharge Date: _____ Number of Visits: _____

Patient Name: _____ Dx: _____

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)

| Activity | Score | | | | |
|---|---|---|---|---|---|
| 1. Sleep normally | 0 | 1 | 2 | 3 | 4 |
| 2. Up and down stairs | 0 | 1 | 2 | 3 | 4 |
| 3. Food Prep, cooking, eating | 0 | 1 | 2 | 3 | 4 |
| 4. Walking | 0 | 1 | 2 | 3 | 4 |
| 5. Grooming (bath, comb hair, shave, etc) | 0 | 1 | 2 | 3 | 4 |
| 6. Getting up and down from a chair or bed | 0 | 1 | 2 | 3 | 4 |
| 7. Dressing—manage normal dressing activities | 0 | 1 | 2 | 3 | 4 |
| 8. Dressing—tie shoes, button shirt | 0 | 1 | 2 | 3 | 4 |
| 9. Lifting, carrying up to 10 pounds | 0 | 1 | 2 | 3 | 4 |
| 10. Sitting for normal periods of time | 0 | 1 | 2 | 3 | 4 |
| 11. Standing for normal periods of time | 0 | 1 | 2 | 3 | 4 |
| 12. Reaching above head or across body | 0 | 1 | 2 | 3 | 4 |
| 13. Leisure, recreational, sports activities | 0 | 1 | 2 | 3 | 4 |
| 14. Squatting down to pick up item | 0 | 1 | 2 | 3 | 4 |
| 15. Running, jogging | 0 | 1 | 2 | 3 | 4 |
| 16. Driving | 0 | 1 | 2 | 3 | 4 |
| 17. Job requirements— can do all activities required of my job | 0 | 1 | 2 | 3 | 4 |

**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 pain.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|