



# Functional Assessment Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

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

**Key: (0 = no difficulty 5 = unable)**

Activity	Score					
	No Difficulty			Unable		
1. Sleep normally	0	1	2	3	4	5
2. Up and down stairs	0	1	2	3	4	5
3. Food prep, cooking, eating	0	1	2	3	4	5
4. Walking	0	1	2	3	4	5
5. Grooming (bath, comb hair, shave, etc.)	0	1	2	3	4	5
6. Getting up and down from chair or bed	0	1	2	3	4	5
7. Dressing - manage normal dressing activities	0	1	2	3	4	5
8. Dressing - tie shoes, buttons shirt	0	1	2	3	4	5
9. Lifting, carrying up to 10 pounds	0	1	2	3	4	5
10. Sitting for normal periods of time	0	1	2	3	4	5
11. Standing for normal periods of time	0	1	2	3	4	5
12. Reaching above head or across body	0	1	2	3	4	5
13. Leisure, recreational, sports activities	0	1	2	3	4	5
14. Squatting down to pick up item	0	1	2	3	4	5
15. Running, jogging	0	1	2	3	4	5
16. Driving	0	1	2	3	4	5
17. Job requirements - can do all activities required of my job	0	1	2	3	4	5

**Pain Scale:** Please circle the number that describes the pain/symptoms you have experienced over the last week with (0) being no pain/symptoms and (10) the worst imaginable pain/symptoms

0	1	2	3	4	5	6	7	8	9	10
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What activities are your symptoms preventing you from doing that you would like to do?

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