

Patient-Specific Functional Scale

Name: _____

Date: _____

Please read the following and complete.

Please identify **up to three important activities** that you are **unable** to do or are **having difficulty with** as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy). Today, are there any activities that you are **unable** to do or having difficulty with because of your problem/diagnosis?

Please rate each of these problems on the 0-10 scale below.

0 = Able to perform activity at the same level as before injury or problem (No issues)

10 = Unable to perform activity (Cannot perform)

Patient-specific activity scoring scheme (Circle one number or provide a range):

1. Activity:											
0	1	2	3	4	5	6	7	8	9	10	
No Issues									Cannot perform		

2. Activity:											
0	1	2	3	4	5	6	7	8	9	10	
No Issues									Cannot perform		

3. Activity:											
0	1	2	3	4	5	6	7	8	9	10	
No Issues									Cannot perform		