Office Use Only:
MRN

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**