

**PATIENT FUNCTIONAL ASSESSMENT QUESTIONNAIRE**

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

INSTRUCTIONS: Circle the level of difficulty for each activity.		0 = Absolute no difficulty	1 = Able to do w little difficulty	2 = Able to do w lit-mod difficulty	3 = Able to do w mod difficulty	4 = Able to do w mod-signif difficulty	5 = Able to do w signif difficulty	6 = Unable to do at all	Not applicable	
<b>MOBILITY/WALKING</b>	1	Walking short distances	0	1	2	3	4	5	6	n/a
	2	Walking long distances	0	1	2	3	4	5	6	n/a
	3	Walking outdoors	0	1	2	3	4	5	6	n/a
	4	Climbing stairs	0	1	2	3	4	5	6	n/a
	5	Hopping	0	1	2	3	4	5	6	n/a
	6	Running	0	1	2	3	4	5	6	n/a
<b>CHANGE/MAINTAIN BODY POSITION</b>	1	Rolling over	0	1	2	3	4	5	6	n/a
	2	Moving - lying to sitting	0	1	2	3	4	5	6	n/a
	3	Sitting	0	1	2	3	4	5	6	n/a
	4	Bending/Stooping	0	1	2	3	4	5	6	n/a
	5	Kneeling	0	1	2	3	4	5	6	n/a
	6	Standing	0	1	2	3	4	5	6	n/a
<b>CARRY/MOVE/ HANDLE OBJECTS</b>	1	Pushing	0	1	2	3	4	5	6	n/a
	2	Pulling	0	1	2	3	4	5	6	n/a
	3	Reaching	0	1	2	3	4	5	6	n/a
	4	Grasping	0	1	2	3	4	5	6	n/a
	5	Lifting	0	1	2	3	4	5	6	n/a
	6	Carrying	0	1	2	3	4	5	6	n/a
<b>SELF CARE</b>	1	Dressing/Clasp b/h back	0	1	2	3	4	5	6	n/a
	2	Doing light housework	0	1	2	3	4	5	6	n/a
	3	Prep meals/kitchen tasks	0	1	2	3	4	5	6	n/a
	4	Bathroom activities	0	1	2	3	4	5	6	n/a
	5	Sleeping Ability	0	1	2	3	4	5	6	n/a
	6	Hygiene (comb hair/brush teeth)	0	1	2	3	4	5	6	n/a

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
REVIEWED BY THERAPIST / CREDENTIALS

\_\_\_\_\_  
DATE