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
MOBILITY/WALKING	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
CHANGE/MAINTAIN BODY POSITION	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
CARRY/MOVE/ HANDLE OBJECTS	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
SELF CARE	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**

Version 001