Arch Health Partners

Patient Name: _____
DOB: _____
MRN: _____

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

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

Key: (**0** = unable) (**1** = very difficult) (**2** = moderately difficult) (**3**= minimally difficult) (**4** = normal)

ACTIVITY	SCORE
1. **Sleep Normally**	**0 1 2 3 4**
2. Up and Down Stairs	**0 1 2 3 4**
3. Food Prep / Cooking / Eating	**0 1 2 3 4**
4. Walking	**0 1 2 3 4**
5. Grooming (bath, comb hair, shave, etc.)	**0 1 2 3 4**
6. Getting In / Out of a Chair or Bed	**0 1 2 3 4**
7. Dressing – normal dressing activities	**0 1 2 3 4**
7a. Dressing – tie shoes / button shirt	**0 1 2 3 4**
8. Lifting / Carrying 10 pounds	**0 1 2 3 4**
9. Sitting for normal periods of time	**0 1 2 3 4**
10. Standing for normal periods of time	**0 1 2 3 4**
11. Reaching above head or across body	**0 1 2 3 4**
12. Leisure / Recreational / Sports Activities	**0 1 2 3 4**
13. Squatting down to pick up an item	**0 1 2 3 4**
14. Running / Jogging	**0 1 2 3 4**
15. Driving	**0 1 2 3 4**
16. Job Requirements – can do all activities required of my job	**0 1 2 3 4**
PAIN SCALE: Please circle the number that describes the pain you have experienced over the last week with **0** being **NO pain** and **10** being the **WORST imaginable**	**0 1 2 3 4 5 6 7 8 9 10** No Pain … Worst Pain

For Office Staff: Eval/Progress/Discharge Date: _____DX:_____ Number of Visits:_____