

SELF ASSESSED FUNCTION for

LOWER QUARTER



Physical Therapy... the Neapolitan way

Patient's Name: _____
 Acct. #: _____

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This questionnaire is about the way your leg and/or back pain is affecting your daily life. We would like to know if your problem makes it difficult to perform any of the following activities listed below. Each activity has a scale of 0-10. Please rate each activity (**do not skip any activities**).

Today, do you find it difficult to perform the following activities because of your problem?

(0) = No Difficulty	(1-3) MILD	(4-6) MODERATE	(7-9) SEVERE	(10) Unable To Do	Rating
Activity					
1. Any of your usual work, housework or school activities.					
2. Your usual hobbies, recreational or sporting activities.					
3. Putting on your shoes, socks or pantyhose.					
4. Squatting or Kneeling.					
5. Getting in or out of your car.					
6. Walking 2 blocks.					
7. Walking 1 mile.					
8. Going up or down 10 stairs (approx. 1 flight of stairs).					
9. Standing for 1 hour.					
10. Sitting in a chair for 4 hours.					
11. Running on even ground.					
12. Running on uneven ground.					
13. Balance on 1 leg.					
14. Cross legs while sitting.					
15. Travel 1 hour in the car.					
16. Sleeping for 6 hours.					
17. Bend over sink for 10 minutes.					
18. Take food out of the refrigerator.					
19. Carry two bags of groceries.					
20. Roll over and/or get out of bed.					
21. List any other activity:					
22. List any other activity.					
23. List any other activity.					
24. List any other activity.					

Comments: _____ Total: _____

Patient Signature: _____ Date: _____

BELOW IS FOR OFFICE USE ONLY

Initial
 Progress
 Discharge
 Total Score: _____ / _____ = Average Score: _____