Patient Acct #: ________________
Provider Number: ________________

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410 Main Street, Moville, IA
105 W 3rd St, Ponca, NE

Eval/Progress/Discharge Date: ____________________

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name: ______________________ DX: __________ Number of Visits: _________

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(bathe, comb hair, shave, etc)	0	1	2	3	4
6. Getting up/down from chair or bed	0	1	2	3	4
7. Dressing – manage normal dressing activities.	0	1	2	3	4
8. Lifting/Carrying up to 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 .Recreational/Sports Activities	0	1	2	3	4
13. Squatting down to pick up 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 the worst imaginable.

0	1	2	3	4	5	6	7	8	9	10

Office Use

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