# Patient Specific Functional Scale

Patient: _____ Date: ____/____/____

Please identify and circle important activities that you are unable to do, or have difficulty doing as a result of the problem(s) you are being treated for at this office. Please use these **examples** as a starting point to remind you, but be very **specific** in your response. For example, if housework bothers you, be specific and name the exact part of housework that is difficult, such as "vacuuming", or "cleaning the bathtub". *(Remember, you are not limited to this list, you may choose something else and write them in at the bottom of the list.)*

Examples:

| | |
|---|---|
| Sitting (how long?)<br>Bending<br>Lifting<br>Walking (how far?)<br>Gardening (be specific)<br>Standing in one place<br>Driving<br>Sleeping<br>Putting on socks/shoes<br>Reaching<br>Pushing<br>Pulling<br>Moving in bed<br>Standing up from sitting<br>Stairs<br>Getting out of bed<br>Bathing<br>Sexual activities | Reading<br>Running<br>Sports (be specific)<br>Working (be specific)<br>Carrying (be specific)<br>Lying down<br>Getting in/out of bed<br>Childcare (be specific)<br>Shopping (be specific)<br>Cleaning (be specific)<br>Housework (be specific - Vacuuming, Making beds, Mopping, Dusting, Laundry, etc.)<br>Hobbies (be specific – chess, knitting, crosswords, computer)<br>_____<br>_____<br>_____ |

**Now choose the 3 most important to you** and write them in the boxes below. Please score the difficulty of each activity on the adjacent scale, remembering that "0" indicates that you are totally unable to perform that activity, and "10" indicates that you are perfectly able to perform the activity as well as you could before your problem.

| The three most important activities you are unable to do or have difficulty with as a result of these problem(s): | 0 = Unable To Perform At All: | | | | | | | | | | 10 = Able to Perform as Well as Before Problem |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Please sign here: _____