



FUNCTIONAL ACTIVITIES ASSESEMENT

KEY

- 0= Can NOT do
- 1= Very Difficult/ Painful
- 2= Can do with Difficulty/ Moderate Pain
- 3= Minimal Difficulty/Minimal Pain
- 4= Independent/ No Pain

Patient Name: _____

Diagnosis: _____

Pre-Symptom Activity Tolerance	Functional Activities	Date	Date	Date	Date
	Restful Sleep				
	Rolling over in bed				
	Getting out of bed				
	Walking inside the house				
	Fear of falling or loss of balance				
	Full flight of stairs with rail				
	Full flight of stairs without rail				
	Getting in and out of a car				
	Driving				
	Standing for 10 minutes to do a task				
	Putting on socks				
	Getting in and out of shower/tub				
	Putting on shirt/jacket				
	Pick up a pot				
	Use a hand tool (screwdriver, pliers)				
	Taking a can of food out of an overhead cupboard				
	Moderate Activities (Vacuum, carry groceries, prepare a meal)				
	Vigorous activities (lifting 20+lbs, cutting grass, sweep garage)				
	TOTAL SCORE:				