Unionville Centre for Health
Modern Healthcare in Olde Unionville
(The offices of Dr Fiona Chan and associates)

Thank you for coming to our office. We will try to make your experience as pleasant as possible in a warm and friendly environment.

Please complete **ALL** the questions in the attached sheets. (**Pages 1-8 on the bottom right hand corner**) The more complete information we have, the more accurate our conclusions will be. (**If there are any pages missing, please contact our office**)

Please let us know what we can do to make this experience more comfortable for you.

We are fully compliant with both Federal and Provincial privacy laws. All information is kept secure and is not communicated to any party for any reason except that information which you approve. We would be pleased to discuss any privacy issues with you should you have any concerns.

COMPREHENSIVE/CONFIDENTIAL ASSESSMENT QUESTIONNAIRE

Please complete ALL questions carefully.

Today's Date: D______M______Y_______

PATIENT INFORMATION:

Last Name: ____ First Name: ____

Address: ____ City: ____________________ Postal Code: _______________

Telephone (Res): _________________________ (Bus): ________________________ (Cell): ______________________

Sex: (circle) M / F Date of Birth: D_____M_____Y________ Marital Status: (circle) M W S D

Occupation:____ Please circle: Full-Time or Part-Time

Health Card No.: ________________________ Version Code: ______ e-mail: _________________________________

Number of Children: _____ Ages: ____/____/____/____ Referred by: ______________________________________
(e.g., name of friend / family / doctor / sign / yellow pages)

DOCTOR INFORMATION:

Family Doctor:________________________________ Telephone:____________________ Fax:_____________________

Address: ____ City: ____________________ Postal Code: _______________

INSURANCE INFORMATION (if applicable):

Do you have an Extended Health Plan: (circle) NO YES

Check coverage: ( ) Chiro ( ) Orthotics ( ) Physio ( ) Psychology ( ) Acupuncture ( ) Massage

Name of Insured: _____________________________ Insurance Co.:____

Address: ____ City: ____________________ Postal Code: _______________

Telephone: _______________________ Fax: ________________________ Policy#: ______________________________

EMERGENCY CONTACT:

Name:____ Telephone:__________________________________

2 Millstone Court
Unionville, Ontario L3R 7M1
Tel: (905) 475-8386 Fax: (905) 534-7666

1. When did your symptoms first begin?: ____

2. What is your greatest concern at this time? ____
____
____

3. Do you feel your problem is (circle one) a) temporary or b) permanent

4. On a scale of 0 to 100, where 100 is normal, **how much have you recovered SYMPTOMATICALLY (how you feel)** since the onset of the problem:

   0----------10----------20----------30----------40----------50----------60----------70----------80----------90---------100
   no improvement / slight improvement / moderate / marked improvement / almost no symptoms / fully recovered

5. On a scale of 0 to 100, where 100 is normal, **how much have you recovered FUNCTIONALLY (what you can do)** since the onset of the problem:

   0----------10----------20----------30----------40----------50----------60----------70----------80----------90---------100
   no improvement / slight improvement / moderate / marked improvement / almost no symptoms / fully recovered

6. **Name:______________________________ Date:______/______/______**

PAIN DIAGRAM:

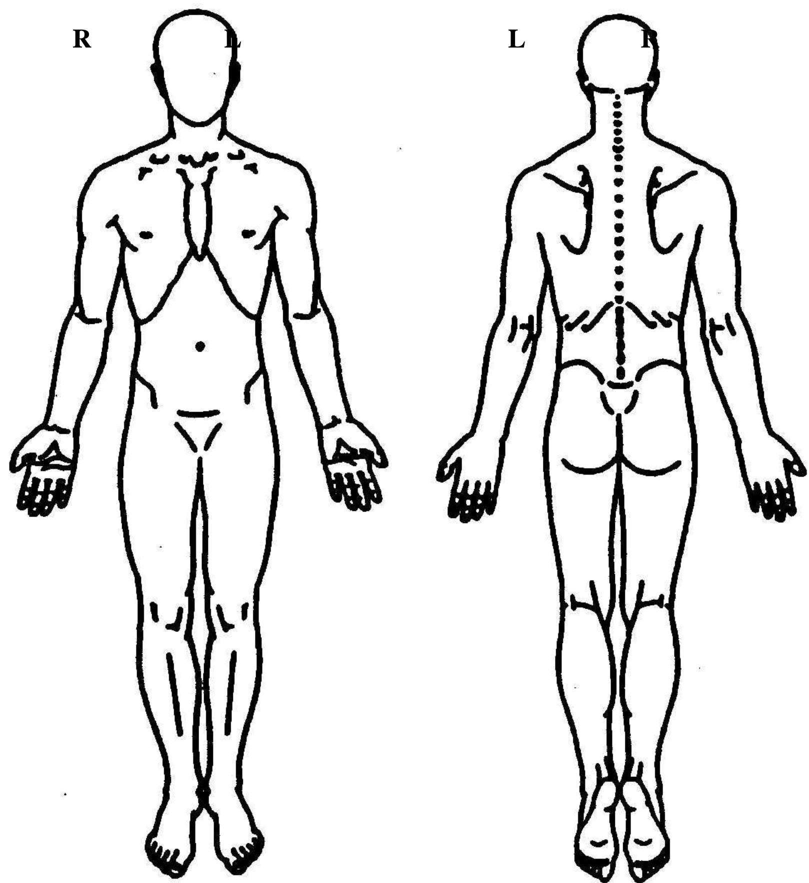
Check if you have any of the following pain symptoms:

- □ **Pain** □ **Numbness** □ **Weakness** □ **Electric Shock**
- □ **Pins & Needles** □ **Itching** □ **Tingling**

On the diagram, draw where you have these symptoms….use the following symbols

Pain PPP Numbness OOO Weakness WWW Electric Shock SSS

Itching III Pins & Needles/Tingling ZZZ



Write any comments or concerns that you would like the doctor to focus on: ________________________________
____
____
____

7. Please **indicate your present level of pain/severity for each of the body areas listed using this Symptom Rating Scale below**: **(Mark a number in each region-0 if no pain problems X if no complaint in the region)**

1---------------2---------------3---------------4---------------5---------------6---------------7---------------8---------------9---------------10
mild pain moderate pain marked pain severe pain excruciating pain

Symptoms description: Feel free to use these terms to describe your symptoms in each section, or add your own (eg. pain, sharp, dull, achy, numbness, tightening, stiffness, weakness, burning, stabbing, pins & needles, tingling)

a. **Headaches**: **(Pain level 1-10)** [ ]

Describe your symptoms____
Location ____________________ Aggravating factors ____________________
Frequency ____________________ Relieving factors ____________________
Duration ____________________

b. **Face (TMJ-jaw): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ____________________ Aggravating factors ____________________
Frequency ____________________ Relieving factors ____________________
Duration ____________________

c. **Neck: (Pain level 1-10)** [ ]

Describe your symptoms____
Location ____________________ Aggravating factors ____________________
Frequency ____________________ Relieving factors ____________________
Duration ____________________

d. **Upper Trapezii (Areas between neck and shoulder joint): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ____________________ Aggravating factors ____________________
Frequency ____________________ Relieving factors ____________________
Duration ____________________

e. **Shoulder Blades ("Wingbone"/Scapula): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ____________________ Aggravating factors ____________________
Frequency ____________________ Relieving factors ____________________
Duration ____________________

f. **Shoulders and Upper Arms: (Pain level 1-10)** [ ]

Describe your symptoms____
Location ____________________ Aggravating factors ____________________
Frequency ____________________ Relieving factors ____________________
Duration ____________________

g. **Elbows: (Pain level 1-10)** [ ]

Describe your symptoms____
Location ____________________ Aggravating factors ____________________
Frequency ____________________ Relieving factors ____________________
Duration ____________________

h. **Forearms and/or Wrists (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

i. **Hands and Fingers (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

j. **Upper Back (Thoracic): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

k. **Lower Back (Lumbar): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

l. **Hips/Pelvis/S.I./Groin (Circle all affected areas): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

m. **Buttocks: (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

n. **Thighs and/or Knees (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

o. **Lower Leg and/or Ankles (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

p. **Feet and Toes (Circle either or both where appropriate): (Pain level 1-10)** [ ]

Describe your symptoms____
Location ________________________________ Aggravating factors ________________________________
Frequency ________________________________ Relieving factors ________________________________
Duration ________________________________

q. **Sleep:** [ ] Difficult falling asleep [ ] Wake up ________/per night

How long does it take to fall asleep? __________ minutes How much sleep do you get? _________ hours

On average how many hours do you: Spend in bed? __________ Spend sleeping? __________

r. **Psychological:** Increased challenges with any of the following (check all that apply):

[ ] Anxiety [ ] Concentration [ ] Depression [ ] Dizziness [ ] Driving [ ] Irritability [ ] Memory [ ] Stress

s. **Other symptoms:** ____

____

____

8. Please indicate specifically any **current** treatments that you are receiving with a number indicating the frequency in the **Times/wk** box (Place a **P** to the right of the **Times/wk** box if the treatment was done in the PAST (but not currently):

	Dr/Therapist Name	Times/wk	Helpful (check)		Dr/Therapist Name	Times/wk	Helpful (check)
Acupuncture	____________	[ ] ___	[ ]	NET	____________	[ ] ___	[ ]
Aqua therapy	____________	[ ] ___	[ ]	Nutrition	____________	[ ] ___	[ ]
Chiropractic	____________	[ ] ___	[ ]	Physiotherapy	____________	[ ] ___	[ ]
Exercise therapy	____________	[ ] ___	[ ]	Psychotherapy	____________	[ ] ___	[ ]
Graston	____________	[ ] ___	[ ]	TMJ (jaw therapy)	____________	[ ] ___	[ ]
Massage therapy	____________	[ ] ___	[ ]	Other	____________	[ ] ___	[ ]
Other	____________	[ ] ___	[ ]	Other	____________	[ ] ___	[ ]

9. **What activities are you having problems with or do you find aggravating? (circle):**

1) Accounting **2)** Balance **3)** Bending **4)** Computer/Keyboard Use **5)** Dressing **6)** Eating **7)** Fatigue
8) Fine Hand Activities **9)** Food Preparation **10)** Gripping **11)** Housework **12)** Hygiene **13)** Kneeling **14)** Lifting
15) Pulling **16)** Pushing **17)** Reaching **18)** Reading **19)** Recreation **20)** Self-Care **21)** Sexual Function
22) Shopping **23)** Sitting **24)** Sleeping **25)** Stairs **26)** Standing **27)** Stooping **28)** Transportation/Travel
29) Walking **30)** Others ____

10. **Which of the following provides some relief or comfort? (circle):**

Acupuncture / Aqua therapy / Changing position / Chiropractic / Electrical modalities (IFC/TENS) / Exercise / Heat / Ice / Lying down / Massage therapy / Osteopathy / Physiotherapy / Rest / Stretching / Other__________________________

11. **Surgery (type and year): Circle any that apply and provide year in space**

Appendix	______	Breast	______	Gall bladder	______	Hernia	______	Tonsillectomy	______
Hysterectomy	______	Prostate	______	Wisdom Teeth	______	Intestinal	______	Cardiac	______
Bone	______	Joint	______	Other(s):	________________, ________________				

12. For any problems experienced by you (use S-self) and/or anyone in your family (use F-family), please indicate as follows**:** --

AIDS	[ ]	Fainting	[ ]	Memory problems	[ ]
Arthritis	[ ]	Faulty posture	[ ]	Mental disorders	[ ]
Asthma	[ ]	Foot Trouble	[ ]	Nerve problems	[ ]
Bladder, kidney, bowel	[ ]	Heart disease	[ ]	Neurological disease	[ ]
Cancer of ____________	[ ]	Hernia	[ ]	Obesity	[ ]
Cholesterol	[ ]	HIV (AIDS) exposure	[ ]	Osteoporosis	[ ]
Diabetes	[ ]	High blood pressure	[ ]	Seizures	[ ]
Digestive problems	[ ]	Hypertension	[ ]	Stroke	[ ]
Drug/Alcohol abuse	[ ]	Liver disease	[ ]	Thyroid disease	[ ]
Eyes, ear, nose, throat	[ ]	Lung problems/asthma	[ ]	Other ____________	[ ]

13. **Females only:**
Menstrual [ ] PMS [ ] Are you pregnant YES NO

14. If adopted please indicate: ☐ Yes ☐ No

15. Are you currently limited in the work you can do compared to before your injuries?

☐ No Reduction ☐ Modified Duties ☐ Reduced Hours ☐ Not Working

Details: ____

____

16. Check the appropriate box:

Smoking: [ ] never [ ] quit ____ years(s) ago [ ] smoke ____ pack/day now
Alcohol: [ ] never [ ] seldom 1-4/month [ ] regular 3-5/wk [ ] daily ____oz. daily
Caffeine: [ ] never [ ] occasional coffee/tea [ ] 1-3 cups daily [ ] over 5 cups/daily
Diet: [ ] regular food [ ] vegetarian [ ] recent weight gain/loss (see below)
Recreational Drugs: [ ] never [ ] tried in past, not currently
[ ] currently: Frequency________________ Type:________________

17. What is your height: ______________________________ Weight: ______________
Any recent change in your weight (gain / loss) _________ How much gain/loss? _______________

18. Allergies: [ ] None [ ] Yes (List Below):

____

19. List any serious accidents, falls, hospitalization (type and year):

____

____

20. Fractures: Which bones ________________________________What age:________________________________

21. List previous medications: ____

____

22. List present medications: provide name, amount (Dosage in mgs), how often (Frequency) and for how long they have been taken (Duration) in the chart below: If you need additional space, please list them on a separate page.

Name of medication	Dosage	Frequency	Duration	Reason for taking medication

23. List present supplements: provide name, amount (Dosage in mgs), how often (Frequency) and for how long they have been taken (Duration) in the chart below: If you need additional space, please list them on a separate page.

Name of supplement	Dosage	Frequency	Duration	Reason for taking supplement

24. When did you last feel 100% healthy? ____________________ Is this one of your goals? (circle one) **YES** **NO**

- **EXAM CONSENT:** I consent to an examination/treatment in this office and distribution of reports to appropriate professionals.
- **HEALTH CARD CONSENT:** I release my health card number by the Ministry of Health if requested by this office.
- **RELEASE OF INFORMATION:** I consent to the release of information to third party and other professionals.

____ (Signature of patient/claimant, parent or guardian) ________________ (Date) ________________________________ (Witness)

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

Claimant Name: ____ Date: ____________

This questionnaire has been designed to give the doctor information as to how low back pain has affected your ability to manage everyday life. **Please answer every section**. We realize you may consider that two of the statements in any one section relate to you, but please just **mark only ONE box in that section** that most closely describes your problem.

SECTION 1 – PAIN INTENSITY
- ☐ The pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate.
- ☐ The pain is moderate and does not vary much.
- ☐ The pain comes and goes and is severe.
- ☐ The pain is severe and does not vary much.

SECTION 2 – PERSONAL CARE
- ☐ I would not have to change my way of washing or dressing in order to avoid pain.
- ☐ I do not normally change my way of washing or dressing even though it causes some pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ☐ Because of the pain I am unable to do some washing and dressing without help.
- ☐ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 – LIFTING
- ☐ I can lift heavy weight without extra pain.
- ☐ I can lift heavy weights but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table)
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

SECTION 4 – WALKING
- ☐ I have no pain on walking.
- ☐ I have some pain on walking but it does not increase with distance.
- ☐ I cannot walk more than one km. Without increasing pain.
- ☐ I cannot walk more than ½ km without increasing pain.
- ☐ I cannot walk more than ¼ km without increasing pain.
- ☐ I cannot walk at all without increasing pain.

SECTION 5 – SITTING
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favourite chair as long as I like.
- ☐ Pain prevents me from sitting more than an hour.
- ☐ Pain prevents me from sitting more than a ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ I avoid sitting because it increases pain straight away.

SECTION 6 – STANDING
- ☐ I can stand as long as I want without pain.
- ☐ I have some pain on standing but it does not increase with time.
- ☐ I cannot stand for longer than one hour without increasing pain.
- ☐ I cannot stand for longer than ½ hour without increasing pain.
- ☐ I cannot stand for longer than 10 minutes without increasing pain.
- ☐ I avoid standing because it increases the pain straight away.

SECTION 7 – SLEEPING
- ☐ I get no pain in bed.
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of pain my normal night's sleep is reduced by less than ¼.
- ☐ Because of pain my normal night's sleep is reduced by less than ½.
- ☐ Because of pain my normal night's sleep is reduced by less than ¾.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE
- ☐ My social life is normal and gives me no pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- ☐ Pain has restricted my social life and I do not go out very often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have hardly any social life because of the pain.

SECTION 9 – TRAVELLING
- ☐ I get no pain while travelling.
- ☐ I get some pain while travelling, but none of my usual forms of travel make it worse.
- ☐ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- ☐ Pain restricts all forms of travel.
- ☐ Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

____________ X 2 = ___________%

Pain Severity Scale:
Rate the Severity of your pain by checking one box on the following scale where 0 is NO PAIN and 10 is Excruciating Pain

0	1	2	3	4	5	6	7	8	9	10

NECK PAIN AND DISABILITY INDEX (VERNON-MIOR)

Claimant Name: ____ Date: ____________

This questionnaire has been designed to give the doctor information as to how neck pain has affected your ability to manage everyday life. **Please answer every section**. We realize you may consider that two of the statements in any one section relate to you, but please just **mark only ONE box in that section** that most closely describes your problem.

SECTION 1 - PAIN INTENSITY
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – LIFTING
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it causes extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table).
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – READING
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

SECTION 5 – HEADACHES
- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all.

SECTION 7 – WORK
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

SECTION 8 – DRIVING
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

SECTION 9 – SLEEPING
- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1 to 2 hours sleepless).
- ☐ My sleep is moderately disturbed (2 to 3 hours sleepless).
- ☐ My sleep is greatly disturbed (3 to 5 hours sleepless).
- ☐ My sleep is completely disturbed (5 to 7 hours sleepless).

SECTION 10 – RECREATION
- ☐ I am able to engage in all my recreation activities with no neck pain at all.
- ☐ I am able to engage in all my recreation activities, with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ☐ I can hardly do any recreation activities because of pain in my neck.
- ☐ I can't do any recreation activities at all.

____________ X 2 = ___________%

Pain Severity Scale:
Rate the Severity of your pain by checking one box on the following scale where 0 is NO PAIN and 10 is Excruciating Pain

0	1	2	3	4	5	6	7	8	9	10

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE: _____/ 80

Please submit the sum of responses to ACN.

Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.

THE UPPER EXTREMITY FUNCTIONAL INDEX (UEFI)

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

	Activities	**Extreme Difficulty or Unable to Perform Activity**	**Quite a Bit of Difficulty**	**Moderate Difficulty**	**A Little Bit of Difficulty**	**No Difficulty**
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities	0	1	2	3	4
3	Lifting a bag of groceries to waist level	0	1	2	3	4
4	Lifting a bag of groceries above your head	0	1	2	3	4
5	Grooming your hair	0	1	2	3	4
6	Pushing up on your hands (eg from bathtub or chair)	0	1	2	3	4
7	Preparing food (eg peeling, cutting)	0	1	2	3	4
8	Driving	0	1	2	3	4
9	Vacuuming, sweeping or raking	0	1	2	3	4
10	Dressing	0	1	2	3	4
11	Doing up buttons	0	1	2	3	4
12	Using tools or appliances	0	1	2	3	4
13	Opening doors	0	1	2	3	4
14	Cleaning	0	1	2	3	4
15	Tying or lacing shoes	0	1	2	3	4
16	Sleeping	0	1	2	3	4
17	Laundering clothes (eg washing, ironing, folding)	0	1	2	3	4
18	Opening a jar	0	1	2	3	4
19	Throwing a ball	0	1	2	3	4
20	Carrying a small suitcase with your affected limb	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/80**

Source: Stratford PW, Binkley, JM, Stratford DM (2001): Development and initial validation of the upper extremity functional index. Physiotherapy Canada. 53(4):259-267.