Current Functional Status

Instructions

Please read carefully and fill this form out as accurately as possible. Your insurance company uses this list to determine your need for physical therapy and how much your injury affects your functional ability.

Patient Name ________________ Date ________________

What is your current daily pain level on average 0-10?
(0 = no pain at all, 10 = so intense, it is incapacitating) ____________________

Please rate your ability to perform these daily activities

	Completely Unable	Severe pain	Moderate pain	Mild discomfort	Fully able	Not Applicable
Personal Care	0	1	2	3	4	N/A
Household Mobility	0	1	2	3	4	N/A
Community Mobility	0	1	2	3	4	N/A
Sitting Tolerance (30 mins)	0	1	2	3	4	N/A
Stair Climbing (2 flights)	0	1	2	3	4	N/A
Standing Tolerance (30 mins)	0	1	2	3	4	N/A
Household Chores	0	1	2	3	4	N/A
Lift Objects 1-10 lb	0	1	2	3	4	N/A
Lift Objects 10-20 lb	0	1	2	3	4	N/A
Work Tolerance	0	1	2	3	4	N/A
Sports/Recreation	0	1	2	3	4	N/A
Walking (30 min)	0	1	2	3	4	N/A
Running	0	1	2	3	4	N/A
Driving (60 mins)	0	1	2	3	4	N/A
Getting in and out of car	0	1	2	3	4	N/A
Ability to sleep (6 hours)	0	1	2	3	4	N/A
Rolling over in bed	0	1	2	3	4	N/A
Getting in and out of bed	0	1	2	3	4	N/A
Squatting	0	1	2	3	4	N/A
Kneeling	0	1	2	3	4	N/A
Putting on shoes and socks	0	1	2	3	4	N/A
Reaching overhead	0	1	2	3	4	N/A
Getting up from a chair	0	1	2	3	4	N/A

Signature ____________________ Name ____________________

Signature of the Person Submitting this Form *Name of the Person Submitting this Form (print)*