Patient Name:______________ Date:_____________ Diagnosis_________________

FUNCTIONAL ACTIVITIES CHECKLIST

Check One: Initial Visit ☐ Final Visit ☐ THERAPIST__________________

1. How well are you able to perform the following activities?:

Activities	No Difficulty Doing	Mild Difficulty Doing	Moderate Difficulty Doing	Unable to Do	NA (Didn't perform prior to symptoms)
Moving to/from a seated position	0	1	2	3	NA
Turning over in bed	0	1	2	3	NA
Sleeping through the night	0	1	2	3	NA
Reaching up over your head	0	1	2	3	NA
Doing light house work (dusting, sweeping, etc.)	0	1	2	3	NA
Bending/Lifting an object off the floor	0	1	2	3	NA
Lifting/carrying groceries	0	1	2	3	NA
Walking up/down 1 flight of stairs	0	1	2	3	NA
Walking one block distance	0	1	2	3	NA
Driving a car	0	1	2	3	NA
Riding in a car (at least 20 minutes)	0	1	2	3	NA
Doing moderate activities (moving a table, pushing a vacuum, bowling, golf, etc.)	0	1	2	3	NA
Vigorous activities (running, lifting heavy objects, sporting activities, etc.)	0	1	2	3	NA

If Pain is Present:

1. Please rate the intensity of your pain, on average.

   0 1 2 3 4 5 6 7 8 9 10

   No Pain Weak Pain Moderate Pain Strong Pain Unbearable Pain

2. What percent of the day do you have pain?______________
3. On average, how many days a week do you have pain?___________________