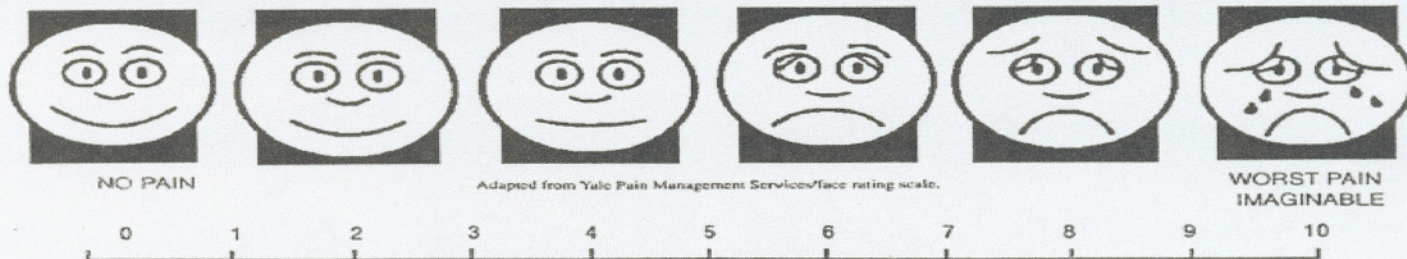


Cervical and Upper Extremity Functional Assessment

Name: _____

Start Date: _____

(Mark with I-Initial & D-Discharge)



1. Rate the intensity of your pain/symptoms AT THIS TIME:

In regards to the problem that brought you to therapy, how difficult are the following activities? (Circle number)	Without Difficulty	Minimal Difficulty	Moderate Difficulty	Very Difficult	Almost Impossible	Unable	Comments by Therapist		D/C Score	
1. Roll over in bed, getting up from lying down	0	1	2	3	4	5				
2. Sleeping	0	1	2	3	4	5				
3. Dressing - shirts, belts, bra on/off	0	1	2	3	4	5				
4. Up and down from a chair	0	1	2	3	4	5				
5. Bathing/showering, washing hair or under arm	0	1	2	3	4	5				
6. Combing/styling your hair, shave, grooming, applying make-up	0	1	2	3	4	5				
7. Gripping, holding objects, hand activities such as opening jars	0	1	2	3	4	5				
8. Light housework - making the bed, dishes, dusting	0	1	2	3	4	5				
9. Heavy housework - vacuum, laundry, yard work	0	1	2	3	4	5				
10. Reaching below waist such as into dishwasher, dryer	0	1	2	3	4	5				
11. Reaching overhead such as into cupboards	0	1	2	3	4	5				
12. Driving, turning neck, steering, reaching & fasten safety belt	0	1	2	3	4	5				
13. Carrying groceries, laundry, gallon of milk	0	1	2	3	4	5				
14. Reaching into your back pocket	0	1	2	3	4	5				
15. Work Duties or School Activities	0	1	2	3	4	5				
THERAPIST TO COMPLETE							Initial Score	%	Discharge Total	%

For Therapist's use ONLY:

Specify Dx Category: _____

At time of **DISCHARGE**, patient's reported overall percent improvement that has been achieved? _____

Therapist's Signature: _____ **D/C Date:** _____