

Eval/Progress/Discharge Date: _____

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name: _____ DX: _____ Number of Visits: _____

Using the key below please circle one answer in each box that indicates your ability to do the following activities;

Key: (0 = unable) (1 = very difficult) (2 = moderately difficult) (3 minimally difficult) (4= normal)

| Activity | Score | | | | |
|--|-------|---|---|---|---|
| 1. Sleep normally | 0 | 1 | 2 | 3 | 4 |
| 2. Up and Down Stairs | 0 | 1 | 2 | 3 | 4 |
| 3. Food Prep/Cooking/Eating | 0 | 1 | 2 | 3 | 4 |
| 4. Walking | 0 | 1 | 2 | 3 | 4 |
| 5. Grooming (bath, comb hair, shave, etc) | 0 | 1 | 2 | 3 | 4 |
| 6. Getting up/down from chair or bed | 0 | 1 | 2 | 3 | 4 |
| 7. Dressing – manage normal dressing activities. | 0 | 1 | 2 | 3 | 4 |
| 8. Lifting/Carrying up to 10 pounds. | 0 | 1 | 2 | 3 | 4 |
| 9. Sitting for normal periods of time | 0 | 1 | 2 | 3 | 4 |
| 10. Standing for normal periods of time | 0 | 1 | 2 | 3 | 4 |
| 11. Reaching above head or across body | 0 | 1 | 2 | 3 | 4 |
| 12. Recreational/Sports Activities | 0 | 1 | 2 | 3 | 4 |
| 13. Squatting down to pick up item | 0 | 1 | 2 | 3 | 4 |
| 14. Running/Jogging | 0 | 1 | 2 | 3 | 4 |
| 15. Driving | 0 | 1 | 2 | 3 | 4 |
| 16. Job Requirements – can do all activities my job requires | 0 | 1 | 2 | 3 | 4 |

Pain Scale - Please circle the number that describes the pain you have experienced over the last week with 0 being no pain and 10 the worst imaginable had.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|----|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|----|

Rehabilitation Screening / Medical History

Patient's Name: _____ DOB: _____ Date: _____

Please complete the following questions to the best of your ability. This will help us to develop a treatment plan that will meet your individual needs.

Medicare patients only: Have you had physical, occupational, or speech therapy since January 1, 2009?

Yes _____ No _____

A) Have you fallen at least once in the past year and sustained an injury? Yes _____ No _____

B) Have you fallen at least twice in the past year without an injury? Yes _____ No _____

1. Reason for this visit? _____

2. Date of injury or when problem last caused you to seek medical attention: _____

3. How did your current problem begin? Lifting _____ twisting _____ falling _____ motor vehicle accident _____

Unknown _____ other: _____

4. Were you hospitalized for this problem? Yes _____ No _____ If yes, give dates: _____

5. Are you currently being seen by any of the following? dentist _____ chiropractor _____ osteopath _____
physical therapist _____ occupational therapist _____ home health _____

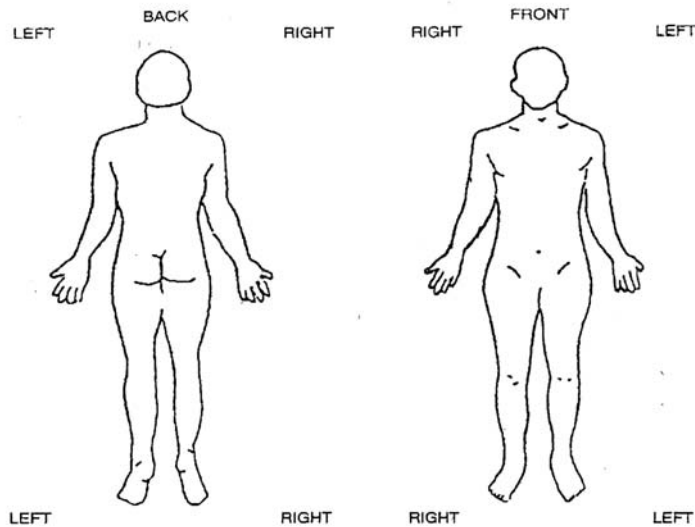
6. If you are seeing any of the above, please describe the reason:

7. What can you no longer do because of your current illness or accident?

8. Current living situation: ___ live alone ___ live with spouse/family ___ live in assistant living ___ other:

9. How would you describe your overall health: ___ excellent ___ very good ___ good ___ fair ___ poor

10. Are you experiencing pain due to your current accident or illness? Yes _____ No _____



11. Rate your pain using the following scale, with 0 being no pain and 10 being very severe pain:

During rest: 0 1 2 3 4 5 6 7 8 9 10
During activity 0 1 2 3 4 5 6 7 8 9 10

12. Have you had therapy for this recent illness? Yes ___ No ___ If you answered yes, please explain where and when and the outcome of the therapy: _____

13. Are you presently working? Yes ___ No ___ Occupation? _____
 If working, what type of duty: light/modified duty ___ regular duty ___

14. Are you left handed ___ right handed ___ 15. Are you pregnant? Yes ___ No ___

16. Prior to your current injury/illness, did you use a: cane ___ walker ___ other: _____ none ___

17. What type of exercise are you currently doing? _____

18. How, if at all, have your exercise and daily activities changed due to your recent illness?

19. Rate your stress level over the past 4 weeks: (circle)

No Stress 0 1 2 3 4 5 6 7 8 9 10 High Stress

20. Any recent significant change in your appetite? Yes ___ No ___

21. Do you currently experience or have experienced any of the following?

- | | | |
|-------------------------|--------------------------|-----------------------------|
| ___ Cardiac Problems | ___ Diabetes | ___ Hypertension |
| ___ Orthopedic Problems | ___ Rheumatoid Arthritis | ___ GI problems |
| ___ Cancer | ___ Seizures | ___ Multiple Sclerosis |
| ___ Fibromyalgia | ___ Depression | ___ Drug/Alcohol Dependency |

22. Have you ever had a broken bone or fracture? Yes ___ No ___

If yes, which body part: _____ When: _____

23. Do you smoke? Yes ___ No ___ If yes, number of packs/day? _____

24. List any medication **allergies** _____

25. List all prescription or over-the-counter medications and dietary / herbal supplements you are currently taking **if you have not provided this information already:**

26. What goals would you like to achieve from therapy?

27. **Emergency Contact Name:** _____

Relationship: _____ **Phone Number:** _____