Clinic Name: RMOA
Eval/Progress/Discharge Date:_____

FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name:_____Date:_____ 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)

Please Note: If you have never done one of these activities, please circle 4.

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**
7a. Dressing – manage normal dressing activities.	**0**	**1**	**2**	**3**	**4**
7b. Dressing – Tie Shoes/Button Shirt	**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. Leisure/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 required of my job.	**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**