RESTORATION BODYCARE

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FUNCTIONAL ABILITIES

PATIENT NAME: _____ DATE: _____

PUT AN "X" UNDER THE LEVEL OF DIFFICULTY YOU HAVE WITH EACH ACTIVITY TODAY.
CONSIDER YOUR LEVEL OF PAIN WHEN ANSWERING.

DIFFICULTY SCALE	0	1	2	3	4
CHANGE/MAINTAIN BODY POSITION	**NO DIFFICULTY**	**A LITTLE DIFFICULTY**	**MODERATE DIFFICULTY**	**SIGNIFICANT DIFFICULTY**	**UNABLE TO DO**
LYING FLAT / SLEEPING					
ROLLING OVER					
TRANSFER TO/FROM LYING					
TRANSFER TO/FROM SITTING					
SITTING > 30 MINUTES					
STANDING > 20 MINUTES					
BENDING / STOOPING					
SQUATTING					
KNEELING					
BALANCING YOUR BODY					
[/ 40] = [% IMPAIRED]					
CARRY/MOVE/HANDLE OBJECTS	**NO DIFFICULTY**	**A LITTLE DIFFICULTY**	**MODERATE DIFFICULTY**	**SIGNIFICANT DIFFICULTY**	**UNABLE TO DO**
PUSHING					
PULLING					
REACHING					
GRASPING					
LIFTING					
CARRYING					
[/ 24] = [% IMPAIRED]					
MOBILITY	**NO DIFFICULTY**	**A LITTLE DIFFICULTY**	**MODERATE DIFFICULTY**	**SIGNIFICANT DIFFICULTY**	**UNABLE TO DO**
WALKING IN HOME 50 FEET					
WALKING IN COMMUNITY 600 FEET					
CLIMBING STAIRS					
HOPPING					
JUMPING					
RUNNING					
DRIVING					
[/ 28] = [% IMPAIRED]					
[/ 92] = [% IMPAIRED]					

FROM THE ABOVE LIST, CHOOSE THE 3 ACTIVITIES YOU WOULD MOST LIKE TO BE ABLE TO DO WITHOUT ANY DIFFICULTY. LIST THEM HERE IN ORDER OF MOST IMPORTANT TO LEAST IMPORTANT.

1 _____

2 _____

3 _____