Atrium Physical Therapy
Patient Specific Functional Scale

Patient Name:_____Date:_____

Please identify up to three important activities that you are unable to do or have difficulty doing as a result of your current problem/diagnosis (i.e. the reason your doctor has referred you to therapy). Today, are there any activities that you are unable to do or have difficulty doing?

Please rate each of these problems on the 0-10 scale below.

10 =Able to perform the activity at the same level as before the injury or problem

0 = Unable to perform the activity

Please circle one number for each activity which you specify:

1. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Cannot perform										**No issues**
2. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Cannot perform										**No issues**
3. Activity:										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Cannot perform										**No issues**

IF you are coming for physical therapy treatment for pain, ON AVERAGE, what has been your pain level performing the above activities in the last 24 hours?										
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No pain					**Moderate Pain**					**Worst Possible Pain**