

Name:

Date:

For each of the following, please mark the statement which best describes you today.

Walking

- I am able to walk any distance without symptoms.
- I am able to walk any distance with some symptoms.
- My symptoms prevent me from walking more than 1 mile.
- My symptoms prevent me from walking more than ½ a mile.
- My symptoms prevent me from walking more than a ¼ mile.

Standing

- I can stand for as long as I want without symptoms.
- I can stand for as long as I want with some symptoms.
- Because of my symptoms I am limited in how long I can stand.
- Because of my symptoms I can only stand for 1 hour or less.
- Because of my symptoms I can only stand for ½ an hour or less.

Sitting

- I can sit in any chair for as long as I want.
- I can sit in any chair for as long as I want with some symptoms.
- My symptoms prevent me from sitting for more than 1 hour.
- My symptoms prevent me from sitting for more than ½ an hour.
- My symptoms prevent me from sitting for more than 15 minutes.

Stairs

- My symptoms do not limit my ability to walk up or down stairs.
- I am able to walk up and down stairs, but experience pain or weakness.
- I am able to walk up and down stairs comfortably with the help of a crutch/cane/rail.
- I am unable to walk up and down more than 1 flight of stairs.
- I am unable to go up and down stairs.

Driving / Traveling

- I do not experience any of my symptoms while driving or traveling.
- I experience my symptoms only when looking at the side or rearview mirrors.
- I can drive / travel for as long as I want with some increase in symptoms.
- My symptoms prevent me from driving / traveling long distances without getting out of the car.
- I cannot drive my car or travel for as long as I want because of my symptoms.

Lifting

- I am able to lift heavy weight without an increase in symptoms.
- I am able to lift heavy weights with some increase in symptoms.
- I can lift heavy weights if they are conveniently positioned i.e. on a table or close to my body.
- Because of my symptoms I can only lift light to medium weight objects.
- I cannot lift or carry any object.

Reaching

- I can reach a high shelf or above my head without any symptoms.
- I can reach a high shelf or above my head with a slight increase in symptoms.
- I can reach a high shelf or above my head with a moderate increase in symptoms.
- Because of my symptoms I am unable to reach above my head, but I am able to reach a lower shelf.
- I cannot reach above my waist without an increase in symptoms.

Working (professionally or at home)

- I am able to perform all of my work duties.
- I am able to perform all of my work with an increase in symptoms.
- I can perform most of my work (moderate duty).
- I can perform some of my work (light duty).
- I cannot work.

Sleeping

- My sleep is not disturbed because of my symptoms.
- My sleep is occasionally disturbed because of my symptoms.
- Because of my symptoms my sleep is mildly disturbed nightly.
- Because of my symptoms, my sleep is moderately disturbed.
- Because of my symptoms my sleep is greatly disturbed.

Recreational / Athletic activities.

please indicate an athletic or recreational activity performed regularly that is limited by your symptoms. _____

- I am able to perform all of my recreational /athletic activities without an increase in symptom.
- I am able to perform all of my recreational/athletic activities with an increase in symptoms.
- I am able to participate in most, but not all, of my recreational/athletic activities.
- I am able to participate in some, but not all, of my recreational/athletic activities.
- I am unable to participate in any of my recreational/athletic activities.

In the past 2 weeks, to what extent have your symptoms interfered with your normal social activities?

- Not at all.
- Slightly.
- Moderately.
- quite a bit.
- extremely.

In the past 2 weeks to what extent have your symptoms affected your emotional well being (feeling sad or anxious)?

- Not at all.
- Slightly.
- Moderately.
- Quite a bit.
- Extremely.

I am aware of my symptoms:

- Never.
- Rarely.
- Sometimes.
- Often.
- Constantly.

Are your symptoms limiting, preventing, or increased by any other activity? If so, please indicate or explain.

Pain

Please indicate along the line below the worst pain experienced in the past 24 hrs.

No Pain

Worst Pain imaginable

Improvement (complete on last visit only)

Please indicate along the line below the amount of improvement you have made since the start of your Physical Therapy treatment.

No improvement

Complete recovery

Work Status

Check all that apply

- I have lost _____ (indicate number) work days due to my condition
- I am limiting my work due my condition.
- I am currently on modified work duty due to my condition.
- I am currently not working because of my condition.

Please indicate the location of your symptoms

