

Self Assessed Function for Lower Quarter

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Patient: _____

MR# _____

This questionnaire is about the way your leg and/or low back pain is affecting your daily life. We would like to know if your problem makes it difficult to perform any of the activities listed below.

Each activity has a scale of 0 - 5. Please check one response for each activity (*do not skip any activities*).

Today, do you find it difficult to perform the following activities because of your problem?

Activity	0 unable to do	1 very difficult	2 fairly difficult	3 somewhat difficult	4 minimally difficult	5 not difficult at all
1. Stand up for 20-30 min.						
2. Walk a few blocks 300-400 yd.						
3. Walk several miles						
4. Run two blocks						
5. Climb a flight of steps						
6. Descend a flight of steps						
7. Balance on one leg						
8. Squat or kneel						
9. Sit in a chair for 4 hours						
10. Cross legs while sitting						
11. Travel one hour in a car						
12. Put on socks (pantyhose)						
13. Work &/or home activities						
14. Recreational/leisure activities						
15. Sleeping for at least 6 hours						
16. Turn over in bed						
17. Get out of bed						
18. Reach up to high shelves						
19. Bend over a sink for 10 min.						
20. Move a table						
21. Pull or push heavy doors						
22. Take food out of the refrigerator						
23. Carry two bags of groceries						
24. Lift 40 lb.						

My expectations for therapy are:

Being exceeded Being met Being partially met Not being met N/A- Being evaluated today

Patient Signature

Date

BOTTOM SECTION FOR OFFICE USE ONLY

Total

0					
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Initial Progress Discharge **Total Score _____ / 24 = Average Score _____**

