

Self Assessed Function for Upper Quarter

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Patient: _____

MR# _____

This questionnaire is about the way your upper back, arm, neck and/or head 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. Check one response option 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. Combing or washing your hair						
2. Reaching across to your other shoulder						
3. Reaching behind your back						
4. Pushing with your arm						
5. Pulling with your arm						
6. Carrying a gallon milk jug						
7. Lifting 8 lb. or more (gallon) over your head						
8. Opening a jar						
9. Gripping tightly with your hand						
10. Turning a key in a lock						
11. Turning a door knob						
12. Computer use or other desk work (writing, telephone use, etc.,)						
13. Picking up small objects with your fingers						
14. Work and/or home activities						
15. Recreational/leisure activities						
16. Sleeping for at least 6 hours						
17. Sleeping on either side						
18. Looking up						
19. Turning your head to either side						
20. Maintaining the position of your head and neck						

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** _____ / 20 = **Average Score** _____