

Functional Activity Questionnaire

Patient Name: _____ **Date:** _____

WORK: What is your Job? _____

What physical things are you required to do at work?

Sitting (how long? _____) Standing (how long: _____)

Lifting (how often? _____ how many pounds? _____)

Other _____

Which of the activities listed below are you having difficulty or discomfort with because of your injury?

(please check)

Walking Approximately how long/far can you walk? _____

Sitting Approximately how long/far can you sit? _____

Standing Approximately how long/far can you stand? _____

Going up stairs Going down stairs Bending over Reaching overhead

Reaching Lifting Carrying Sex

Combing hair Brushing teeth Dressing self Putting on shoes/socks

Sleeping Shaving Bathing Driving

HOUSEWORK: Which activities specifically?

Vacuuming Cleaning tub Dusting Cooking

Laundry Making Bed Doing dishes

YARD WORK: Please give specific activity (ies) _____

RECREATIONAL ACTIVITIES: What do you normally do? (hobbies, sports, etc.) _____

Are there any recreational activities that you are not doing now because of your injury? _____

WHAT ARE YOUR GOALS/EXPECTATIONS FROM PHYSICAL THERAPY? _____