**WOODWARD CHIROPRACTIC**
**Accident and Injury Care**
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## PATIENT SPECIFIC FUNCTIONAL SCALE

Patient: _____ Date: _____

Please identify and check important activities that you are unable to do or have difficulty doing as a result of the problem(s) you are being treated for at this office. Please use these examples as a starting point to remind you, but be very **specific** in your response. For example, if housework bothers you, be specific and name the exact part of housework that is difficult such as "vacuuming," or "cleaning the bathtub."

**Remember, you are not limited to this list; you may choose something else and write them in at the bottom of the list.**

Examples:

___ Sitting (how long?)
___ Bending
___ Lifting
___ Walking (how far?)
___ Gardening (be specific)
___ Standing in one place
___ Driving
___ Sleeping
___ Putting on socks/shoes
___ Reaching
___ Pushing
___ Pulling
___ Moving in bed
___ Standing up from sitting
___ Bathing
___ Reading
___ Running
___ Running
___ Sports (be specific)
___ Working (be specific)
___ Carrying (be specific)
___ Lying down
___ Getting in/out of bed
___ Childcare (be specific)
___ Shopping (be specific)
___ Cleaning (be specific)
___ Housework (ex: vacuuming, dusting, laundry, ect.)
___ Hobbies (ex: chess, knitting, crosswords, ect.)
___ Stairs
___ Sexual Activites

Other:
_____
_____

Now choose the **3 most important** to you and write them in the boxes below. Please score the difficulty of each activity on the adjacent scale.

| The most important activities you are unable to or have difficulty with as a result of these problem(s) | 0- Unable to perform at all | | | | | | 10- Able to perform as well as before problem | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Signature: _____