



ARCATA  
 EUREKA  
 FORTUNA  
 MCKINLEYVILLE  
 HealthSPORT

# Patients' Function Guide

PLEASE PRINT

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Please look at the list below and indicate how your injury has affected your daily life. Circle the number that best applies to your ability to function.

1 = No problem    2 = Can do with some difficulty    3 = Can do with great difficulty    4 = Can't do    5 = Not applicable

Please circle your responses below	Additional Comments
Sitting 1 2 3 4 5	
Standing 1 2 3 4 5	
Squatting 1 2 3 4 5	
Going up or down stairs 1 2 3 4 5	
Walking 1 2 3 4 5	
Transferring Positions (sitting to standing, etc.) 1 2 3 4 5	
Sports/Recreation (running, golfing, etc.) 1 2 3 4 5	
Driving a vehicle 1 2 3 4 5	
Lying down 1 2 3 4 5	
Sleeping at night 1 2 3 4 5	
Lifting/Carrying (groceries, briefcase, etc.) 1 2 3 4 5	
Getting dressed 1 2 3 4 5	
Daily job activities 1 2 3 4 5	
Housework/Yardwork 1 2 3 4 5	
Reaching (overhead, behind back, etc.) 1 2 3 4 5	
Gripping 1 2 3 4 5	
Flexing or extending arm/elbow 1 2 3 4 5	
Movement of mouth/jaw 1 2 3 4 5	
Sexual activity 1 2 3 4 5	
Other: 1 2 3 4 5	

Reviewed by: \_\_\_\_\_