



Functional Assessment Questionnaire

Patient Name _____ Date _____

Using the key below please circle one answer in each box that indicates your ability to do the following activities:

Key: (0 = normal) (1 = minimally difficult) (2 = moderately difficult) (3 = very difficult) (4 = unable)

Activity	Score				
1. Sleep normally	0	1	2	3	4
2. Up and down stairs	0	1	2	3	4
3. Food prep, cooking, eating	0	1	2	3	4
4. Walking	0	1	2	3	4
5. Grooming (bath, comb hair, shave, etc.)	0	1	2	3	4
6. Getting up and down from chair or bed	0	1	2	3	4
7. Dressing - manage normal dressing activities	0	1	2	3	4
8. Dressing - tie shoes, buttons shirt	0	1	2	3	4
9. Lifting, carrying up to 10 pounds	0	1	2	3	4
10. Sitting for normal periods of time	0	1	2	3	4
11. Standing for normal periods of time	0	1	2	3	4
12. Reaching above head or across body	0	1	2	3	4
13. Leisure, recreational, sports activities	0	1	2	3	4
14. Squatting down to pick up item	0	1	2	3	4
15. Running, jogging	0	1	2	3	4
16. Driving	0	1	2	3	4
17. Job requirements - can do all activities required of my job	0	1	2	3	4

Pain Scale: Please circle the number that describes the pain you have experienced over the last week with (0) being no pain and (10) the worst imaginable pain

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

For Office Use Only

SAM Unit: **LEFT** _____ lbs. **Right** _____ lbs.