FUNTIONAL SKILLS/PAIN LIST

PATIENT:_____ ID#:_____

Key: Rate your pain and/or limitation on a scale of 0-10 with 10 being the worst.
X – can't do because of limitation/pain N/A – not required to do

	DATE	DATE	DATE	DATE
I. Dressing/Self Care a. Putting on your shirt				
b. Putting on your pants				
c. Putting on your socks and shoes				
d. Bathing				
e. Grooming				
II. Eating a. Getting the utensils to the mouth				
b. Cutting food				
c. Getting food on to the utensil				
d. Chewing				
III. Cooking a. Chopping/Cutting				
b. Lifting pots/pans or heavy food				
IV. House Cleaning a. Mopping/Vacuuming				
b. Washing dishes				
c. Making beds				
d. Laundry				
e. Taking out garbage				
f. Cleaning the bathtub				
g. Mowing the lawn/Raking leaves				
h. Grocery shopping				
i. Working on your car				
V. Function a. Walking				
b. Washing dishes				
c. Making beds				
d. Laundry				
e. Sexual Activities				
f. Sleeping				
g. Driving				
VI. Sports/Hobbies (if currently perform please list) _____ Any Activity not listed_____				
VII. Work Related Activities Job Title:_____				
a. Lifting (lbs)_____ a. Occasional___ b. Repeatedly___				
b. Bending (how often) _____				
c. Stair Climbing				