

NAME \_\_\_\_\_

Initial Visit     Discharge Visit

DATE \_\_\_\_\_

**FUNCTIONAL INDEX**

Choose the one answer in each section that best describes your condition.

**WALKING**

- Symptoms do not prevent me walking any distance.
- Symptoms prevent me walking more than 1 mile.
- Symptoms prevent me walking more than 1/2 mile.
- Symptoms prevent me walking more than 1/4 mile.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

**WORK**

*(Applies to work in home and outside)*

- I can do as much work as I want to.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all (only light duty).
- I cannot do any work at all.

**PERSONAL CARE**

*(Washing, Dressing, etc.)*

- I can manage all personal care without symptoms.
- I can manage all personal care with some increased symptoms.
- Personal care requires slow, concise movements due to increased symptoms.
- I need help to manage some personal care.
- I need help to manage all personal care.
- I cannot manage any personal care.

**SLEEPING**

- I have no trouble sleeping.
- My sleep is mildly disturbed (less than 1 hr. sleepless).
- My sleep is mildly disturbed (1-2 hrs. sleepless).
- My sleep is moderately disturbed (2-3 hrs. sleepless).
- My sleep is greatly disturbed (3-5 hrs. sleepless).
- My sleep is completely disturbed (5-7 hrs. sleepless).

**RECREATION/SPORTS**

*(Indicate Sport if Appropriate \_\_\_\_\_ )*

- I am able to engage in all my recreational/sports activities without increased symptoms.
- I am able to engage in all my recreational/sports activities with some increased symptoms.
- I am able to engage in most, but not all of my usual recreational/sports activities because of increased symptoms.
- I am able to engage in a few of my usual recreational/sports activities because of my increased symptoms.
- I can hardly do any recreational/sports activities because of increased symptoms.
- I cannot do any recreational/sports activities at all.

**DRIVING**

- I can drive my car or travel without any extra symptoms.
- I can drive my car or travel as long as I want with slight symptoms.
- I can drive my car or travel as long as I want with moderate symptoms.
- I cannot drive my car or travel as long as I want because of moderate symptoms.
- I can hardly drive at all or travel because of severe symptoms.
- I cannot drive my car or travel at all.

**LIFTING**

- I can lift heavy weights without extra symptoms.
- I can lift heavy weights, but it gives extra symptoms.
- My symptoms prevent me from lifting heavy weights, but I manage if they are conveniently positioned. (e.g. on a table)
- My symptoms prevent me from lifting heavy weights, but I manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

**STANDING**

- I can stand as long as I want without increased symptoms.
- I can stand as long as I want, but it gives me extra symptoms.
- Symptoms prevent me from standing for more than 1 hour.
- Symptoms prevent me from standing for more than 30 minutes.
- Symptoms prevent me from standing for more than 10 minutes.
- Symptoms prevent me from standing at all.

**SQUATTING**

- I can squat fully without the use of my arms for support.
- I can squat fully, but with symptoms or using my arms for support.
- I can squat 3/4 of my normal depth, but less than fully.
- I can squat 1/2 of my normal depth, but less than 3/4.
- I can squat 1/4 of my normal depth, but less than 1/2.
- I am unable to squat any distance due to symptoms .

**SITTING**

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- My symptoms prevent me sitting more than 1 hour.
- My symptoms prevent me sitting more than 1/2 hour.
- My symptoms prevent me sitting more than 10 minutes.
- My symptoms prevent me from sitting at all.

*\* Lumbar questions adapted from Oswestry.*

**ACUITY** *(Answer on initial visit.)*

How many days ago did onset/injury occur? \_\_\_\_\_ days

*Please complete opposite side*

**PAIN INDEX**

Please indicate the worst your pain has been in the last 24 hours on the scale below.

\_\_\_\_\_
No Pain Worst Pain Imaginable

PLEASE DO NOT COMPLETE THE FOLLOWING SECTIONS ON FIRST VISIT

**IMPROVEMENT INDEX**

Please indicate the amount of improvement you have made since the beginning of your treatment on the scale below.

\_\_\_\_\_
No Improvement Complete Recovery

**WORK STATUS (check most appropriate)**

- 1. [ ] No lost work time 3. [ ] Return to work with modification 5. [ ] Not employed outside the home
2. [ ] Return to work without restriction 4. [ ] Have not returned to work

Work days lost due to condition: \_\_\_\_\_ days

I am aware that the information gathered on this form may be used anonymously for research or publication. Please initial: \_\_\_\_\_