FUNCTIONAL STATUS QUESTIONNAIRE

Please complete this to the best of your ability.

Place label here

1. Have you had previous therapy for this condition, either here or at another center? ❒ Yes ❒ No
   If YES:
   a. Have you had a decrease in your functional ability since your last therapy? ❒ Yes ❒ No
   b. Have you had a recent surgery for this condition? ❒ Yes ❒ No

2. Was the onset for this condition with the past three months? ❒ Yes ❒ No
   Date: _________________

3. Do you live alone? ❒ Yes ❒ No

4. Are you a caregiver? ❒ Yes ❒ No

5. Are there stairs in your home or leading into your home? ❒ Yes ❒ No
   If YES: How many? _________________

AS OF TODAY …	**Have you had a decreased ability to perform this activity in the last 3 months? (circle one)**	**Do you require assistance with this activity? (ie a person, cane, walker, wheelchair, furniture)**	**If pain with this activity, rate your pain on a scale from 0-10. (0 being no pain and 10 calling 911)**
Are you able to walk around your house without help? ❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	0 1 2 3 4 5 6 7 8 9 10
Are you able to get on/off a chair/toilet without help? ❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	0 1 2 3 4 5 6 7 8 9 10
Are you able to shower/bathe without help? ❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	0 1 2 3 4 5 6 7 8 9 10
Are you able to feed yourself and cut your food without help? ❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	0 1 2 3 4 5 6 7 8 9 10
Are you able to Groom/Dress yourself? (i.e. shaving, washing/combing hair, take on/off shirt/pants and shoes/socks and undergarments) without help? ❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	0 1 2 3 4 5 6 7 8 9 10
Are you able to go up/down stairs without help? ❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	0 1 2 3 4 5 6 7 8 9 10
Are you able to perform toilet hygiene without help? ❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	❒ **Yes** ❒ **No**	0 1 2 3 4 5 6 7 8 9 10