Date : _____ **MA Initials :**

INJECTION : YES NO **Exercise Therapy : YES NO**

Functional Assessment Questionnaire

Patient Name : _____ DOB : _____

Rate on a scale from 0-5 (5 being the highest) how difficult it is to do the following tasks:

Bending or Stooping: 0 1 2 3 4 5

Putting on shoes: 0 1 2 3 4 5

Sleeping: 0 1 2 3 4 5

Standing for an hour: 0 1 2 3 4 5

Going up or down a flight of stairs: 0 1 2 3 4 5

Walking through a store: 0 1 2 3 4 5

Driving for an hour: 0 1 2 3 4 5

Preparing a meal: 0 1 2 3 4 5

Yard work: 0 1 2 3 4 5

Picking up items off the floor: 0 1 2 3 4 5

Patient Changes since last treatment:

Patient changes since the start of treatment:

Describe any functional changes within the last three days (good or bad):

Rate pain symptoms on a scale of 0-10 (10 being the highest):

Pain: _____ Numbness: _____ Tingling: _____ Burning: _____ Tightness: ____

**To Be Completed by MA:

Blood Pressure: _____ HR: _____ Weight: _____ Height: _____

Program Number: _____ Treatment Number: _____ Placement: _____

SpO2: _____ Temperature: _____ Blood Glucose: _____ Respirations: _____