**Date** : _____ **MA Initials :**

**INJECTION : YES** **Exercise Therapy : YES**

**Functional Assessment Questionnaire**

**Patient Name :** John Doe **DOB :** 01/05/1988

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

Bending or Stooping: 3

Putting on shoes: 1

Sleeping: 2

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:** Not Good

**Patient changes since the start of treatment:** Worse

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

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

**Pain: __2___ Numbness: ___5___ Tingling: __6____ Burning: ___7___ Tightness: __5__**

**To Be Completed by MA:

Blood Pressure: ___120/80_____ HR: ___80____ Weight: ____67_____ Height: ____5’7____

Program Number: _____ Treatment Number: ______ Placement: _____

SpO2: ___98___ Temperature: ___98.6___ Blood Glucose: ___115___ Respirations: **16**