

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.

**ACUITY**

*(Answer on initial visit.)*

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

**CONCENTRATION**

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

**HEADACHES**

- I have no headaches at all.
- I have slight headaches which come less than 3 per week.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come 4 or more per week.
- I have severe headaches which come frequently.
- I have headaches almost all of the time.

**READING**

- I can read as much as I want without increased symptoms.
- I can read as much as I want with slight symptoms.
- I can read as much as I want with moderate symptoms.
- I cannot read as much as I want because of moderate symptoms.
- I can hardly read at all because of severe symptoms.
- I cannot read at all.

**TALKING**

- I can talk without any increased symptoms.
- I can talk as long as I want with slight symptoms in my jaws.
- I can talk as long as I want with moderate symptoms in my jaws.
- I cannot talk as long as I want because of moderate symptoms in my jaws.
- I can hardly talk at all because of severe symptoms in my jaws.
- I cannot talk at all.

**EATING**

- I can eat whatever I want without symptoms.
- I can eat whatever I want but it gives extra symptoms.
- Symptoms prevent me from eating regular food, but I can manage if I avoid hard foods.
- Symptoms prevent me from chewing anything other than soft foods.
- I can chew soft foods occasionally, but primarily adhere to a liquid diet.
- I cannot chew at all and maintain a liquid diet.

*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 COMPLETE ON LAST VISIT ONLY**

**IMPROVEMENT INDEX**

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

\_\_\_\_\_

No Improvement Complete Recovery

**WORK STATUS** (at last visit only, 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: \_\_\_\_\_