Patient Specific Functional Scale

Client Name:	Date Completed: (pre treatment)

To help us make the most of your physiotherapy sessions with us, it would be helpful if you could identify up to 3 important activities which you are currently having difficulty with or are unable to do as a result of your current problem(s). Please list these below and score your level of ability between 0 -10:

Activity 1: _____

Scoring System (circle the number relevant to you today)										
0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity										Able to perform the activity at the same level as before the injury or problem
For clinic use only: (Post Rx Score and Date)										

Activity 2: _____

Scoring System (circle the number relevant to you today)										
0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity										Able to perform the activity at the same level as before the injury or problem
For clinic use only: (Post Rx Score and Date)										

Activity 3: _____

Scoring System (circle the number relevant to you today)										
0	1	2	3	4	5	6	7	8	9	10
Unable to perform activity										Able to perform the activity at the same level as before the injury or problem
For clinic use only: (Post Rx Score and Date)										

If you have any specific questions or any other comments to add, please write these below and we can chat through them at your consultation:

_____

_____

Clinic Records Only:		