Patient Specific Functional and Pain Scale (PSFS)

Name: _____ Account Number: _____

Patient Instructions:
You must score a **total of 3 activities, and ONLY 3 activities** that you are having the most difficulty with, or are unable to perform. Please be AS SPECIFIC as possible if you are choosing your own activities. The scoring scale is listed below.

0 = Unable to perform activity	0 1 2 3 4 5 6 7 8 9 10	10 = Able to perform activity at 100%

Specific Activity **Please Pick Only 3**	Scoring Scale 0 - 10			
	Date: _____	Date: _____	Date: _____	Date: _____
Example: Sitting for more than 45 minutes	**4**			
Going from sitting to standing				
Walking up stairs OR down stairs (circle)				
Standing for _____ minutes/hours (circle)				
Sitting for _____ minutes/hours (circle)				
Lifting _____ lbs over head OR from floor (circle)				
Driving for _____ minutes/hours (circle)				
Turning my neck _____ (Left or Right) while driving				
Laying on my _____ (Left or Right) side at night				
Pain while sleeping _____ hours				
Carrying baby/child for _____ minutes/hours (circle)				
Vacuuming for _____ minutes/hours (circle)				
Getting my pants or shoes on/off (circle)				
Getting my coat or shirt on/off (circle)				
Reaching up OR behind your body (circle)				
Specific Activity: (optional)				
Specific Activity: (optional)				
Final Score Entered By Doctor				