Name_____
Date_____
Physician_____

Functional Ability Index

The rating scales below are designed to measure the functional level of several aspects of your life. Respond to each category by indicating the overall functional level you presently possess.

For each of the seven categories of life listed, please circle the number on the scale which describes the level of ability you typically experience. A score of **10** means **NO disability** at all, and a score of **0** signifies that **ALL** of your normal activities have been **disrupted.**

1. **FAMILY/HOME RESPONSIBILITIES**: This category refers to activities related to home or family, i.e., chores, housework, yard work, driving children to school, errands, etc.

0 1 2 3 4 5 6 7 8 9 10

All activities disrupted *No disability*

2. **RECREATION**: Includes hobbies, sports, and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10

All activities disrupted *No disability*

3. **SOCIAL ACTIVITY**: Activities, which involve participation with friends and acquaintances other than family members. Includes dining, parties, theater, concerts, and other social functions.

0 1 2 3 4 5 6 7 8 9 10

All activities disrupted *No disability*

4. **OCCUPATION**: Refers to activities that are part of, or directly related to, one's job. This includes nonpaying jobs, i.e., housewife or volunteer worker.

0 1 2 3 4 5 6 7 8 9 10

All activities disrupted *No disability*

5. **SELF CARE**: Includes activities which involve personal maintenance and independent daily living, i.e., dressing, bathing, driving.

0 1 2 3 4 5 6 7 8 9 10

All activities disrupted *No disability*•

6. **LIFE SUPPORT ACTIVITY**: Includes basic life supporting behaviors, i.e., eating, sleeping, breathing.

0 1 2 3 4 5 6 7 8 9 10

All activities disrupted *No disability*

7. How would you rate your injured body part (back, neck, shoulder, knee, etc.) today as a percentage of normal (0% to 100% scale with 100% being normal)?_____

Office Use Only:
Dx_____ Initial □ Discharge □ W/C □ Completed Tx: yes □ no □

PT_____ Referral Source: MD F and F Pt. Other:_____ # of visits____