Integration Physical Therapy
Functional Questionnaire

Name:______________________________ DOB:__________Patient #:__________

Activities	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
Any of your usual work, housework, or school activities	0	1	2	3	4
Your usual hobbies, recreational or sporting activities	0	1	2	3	4
Squatting	0	1	2	3	4
Going up and down a flight of stairs	0	1	2	3	4
Sitting for 1 hour	0	1	2	3	4
Standing for 1 hour	0	1	2	3	4
Walking 2 blocks	0	1	2	3	4
Walking 1 mile	0	1	2	3	4
Running on even ground	0	1	2	3	4
Running on uneven ground	0	1	2	3	4
Lifting an object from the floor (groceries)	0	1	2	3	4
Sleeping	0	1	2	3	4
Driving	0	1	2	3	4
Seeing	0	1	2	3	4
Concentrating	0	1	2	3	4
Reading	0	1	2	3	4
total /64					

My current pain is 0 1 2 3 4 5 6 7 8 9 10
no pain moderate pain worst pain

Indicate where you have pain or symptoms

ANY HISTORY OF FALLS YES NO
IF YES, DATE OF LAST FALL:________________