

Patient Specific Functional and Pain Scales (PSFS)

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Clinician Instructions: Complete after the history and before the exam.

Initial Assessment:

We want to know what 3 activities in your life you are unable to perform, or are having the most difficulty performing, as a result of your chief problem. Please list and score at least 3 activities that you are unable to perform, or are having the most difficulty performing, because of your chief problem.

Follow Up Assessment:

When you were assessed on _____, you told us you had difficulty with the activities in the table below. Please score these activities that you told us previously you were unable to perform or were having difficulty performing because of your chief problem.

Patient Specific Activity Scoring Scheme (Score one number for each activity for each date):

0=Unable to perform activity	0	1	2	3	4	5	6	7	8	9	10	10=Able to perform activity at same level as before injury or problem
-------------------------------------	----------	----------	----------	----------	----------	----------	----------	----------	----------	----------	-----------	--

Activity	Initial Evaluation		Discharge Evaluation		
	Date:	Date:	Date:	Date:	Date:
1.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
2.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
3.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
4.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
5.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
Totals:					

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature: _____ Date: _____