JOB TITLE_____

BRIEF DESCRIPTION_____

Please check the following functional activities that are difficult or impossible for you to perform at this time *due to the injury or diagnosis for which you were referred to physical/occupational therapy*. Also indicate any activities necessary for the performance of your job. This information will help your therapist develop treatment goals and plans to help improve your function.

Mark "X" if able to do prior to injury /surgery	Mark "X" if required for work	Mark "X" if difficult to perform	FUNCTIONAL ACTIVITIES	How long, how far, to what degree can you perform these activities you checked?
			CLIMBING: Upstairs Downstairs Ladders	
			LIFTING	
			CARRYING	
			REACHING	
			DRIVING	
			SLEEPING	
			TURNING A KEY/DOORKNOB OPEN/CLOSE DOOR	
			OPENING A JAR	
			EATING WITH A FORK OR SPOON	
			PREPARING FOOD WITH A KNIFE	
			DRESSING/BATHING: Buttons/Zippers/Tying Shoes	
			GROOMING: Washing/Combing Hair/Toileting/Hygiene	
			HOUSEHOLD CHORES: Vacuuming, Dishes, Laundry, Ironing, Cooking, Shopping, Bed Making	
			HOME MAINTENANCE: Mowing, Gardening Other:	
			AUTO MAINTENANCE	
			TYPING/WRITING	
			MANAGING CHILDREN	
			PLAYING SPORTS/RECREATIONAL ACTIVITIES	
			PUSHING UP FROM A CHAIR	
			PUSH/PULL A HEAVY OBJECT	
			OTHER:	