TEAYS PHYSICAL THERAPY CENTER

Print Name _____ Signature_____ Date _____/_____/_____

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 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?
			SITTING	
			STANDING	
			WALKING Uphill Downhill Level Surfaces	
			CLIMBING Up Stairs Down Stairs Hillsides	
			RUNNING	
			JUMPING/HOPPING	
			PLAYING SPORTS	
			BENDING FORWARD	
			LIFTING	
			CARRYING	
			STOOPING/SQUATTING	
			DRIVING	
			REACHING	
			DRESSING/BATHING	
			GROOMING	
			HOUSEHOLD CHORES Vacuuming Bed Making Doing Dishes Laundry Ironing Dusting Cooking Shopping	
			HOME MAINTENANCE Mowing Gardening Windows Other:	
			AUTO MAINTENANCE	
			MANAGING CHILDREN	
			TYPING/WRITING	
			SLEEPING	
			ROLLING IN BED	
			TRANSFERS To/From Bed In/Out Chair	
			BALANCE	
			OTHER:	