

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 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 On/Off Toilet In/Out Car	
		BALANCE	
		OTHER:	