

**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 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?
		<b>CLIMBING:</b> Upstairs      Downstairs      Ladders	
		<b>LIFTING</b>	
		<b>CARRYING</b>	
		<b>REACHING</b>	
		<b>DRIVING</b>	
		<b>SLEEPING</b>	
		<b>TURNING A KEY/DOORKNOB OPEN/CLOSE DOOR</b>	
		<b>OPENING A JAR</b>	
		<b>EATING WITH A FORK OR SPOON</b>	
		<b>PREPARING FOOD WITH A KNIFE</b>	
		<b>DRESSING/BATHING:</b> Buttons/Zippers/Tying Shoes	
		<b>GROOMING:</b> Washing/Combing Hair/Toileting/Hygiene	
		<b>HOUSEHOLD CHORES:</b> Vacuuming, Dishes, Laundry, Ironing, Cooking, Shopping, Bed Making	
		<b>HOME MAINTENANCE:</b> Mowing, Gardening Other:	
		<b>AUTO MAINTENANCE</b>	
		<b>TYPING/WRITING</b>	
		<b>MANAGING CHILDREN</b>	
		<b>PLAYING SPORTS/RECREATIONAL ACTIVITIES</b>	
		<b>PUSHING UP FROM A CHAIR</b>	
		<b>PUSH/PULL A HEAVY OBJECT</b>	
		<b>OTHER:</b>	