Collaborative Physical Therapy, PLLC
Postural Restoration Center, Certified

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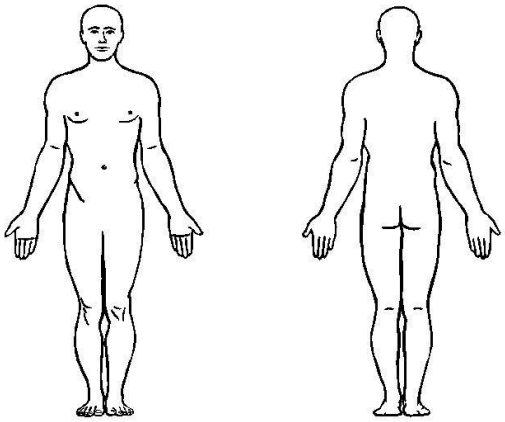
PATIENT-SPECIFIC FUNCTIONAL SCALE

Follow Up

Patient Name _____ Today's Date _____

Height* _____ Weight* _____
(*required by Medicare)

1. On the pictures below, please indicate the location of your issues.



2. On the scale below, please indicate your level of discomfort at its worst and best.

0 1 2 3 4 5 6 7 8 9 10
0 = No discomfort 10 = Extreme discomfort

3. Please identify up to 3 activities that you are unable to do or are having difficulty with (i.e., getting dressed, walking your dog, yard work, sports, etc.).

Activity	Score	✔ which is most limited

4. Please score each activity using the scale below:

Please score each activity using the scale below:

0 1 2 3 4 5 6 7 8 9 10
Able to perform activity at the same level as before problem — Unable to perform activity

Signature _____