Patient Specific Functional and Pain Scales (PSFS)

Patient Last Name	Patient First Name	Patient ID	Date of Birth (MM/DD/YYYY) ____/____/_____
Provider Last Name	Provider First Name	Provider Phone (area code first)	

Clinician Instructions: Complete after the history and before the exam.

Initial Assessment:
We want to know what 3 activities in your life you are unable to perform, or are having the most difficulty performing, as a result of your chief problem. Please list and score at least 3 activities that you are unable to perform, or having the most difficulty performing, because of your chief problem.

Follow-up Assessment:
When you were assessed on _____, you told us that you had difficulty with the following activities. Please score these activities that you told us previously you were unable to perform, or were having the most difficulty performing, because of your chief problem.

Patient Specific Activity Scoring scheme (Score one number for each activity for each date):

0=Unable to perform activity **0 1 2 3 4 5 6 7 8 9 10** **10=Able to perform activity at same level as before injury or problem**

Activity	Date:	Date:	Date:	Date:	Date:
1.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
2.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
3.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
4.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
5.	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)	Score (0-10)
Totals:					

I understand that the information I have provided above is current and complete to the best of my knowledge.

Signature _____ Date _____

Patient Specific Functional Scale reprinted with permission from Straford P, Gill C, Westaway M, Binkley J. Assessing disability and change on individual patients: A report of a patient specific measure. Physiother Can 1995; 47:258-263.