

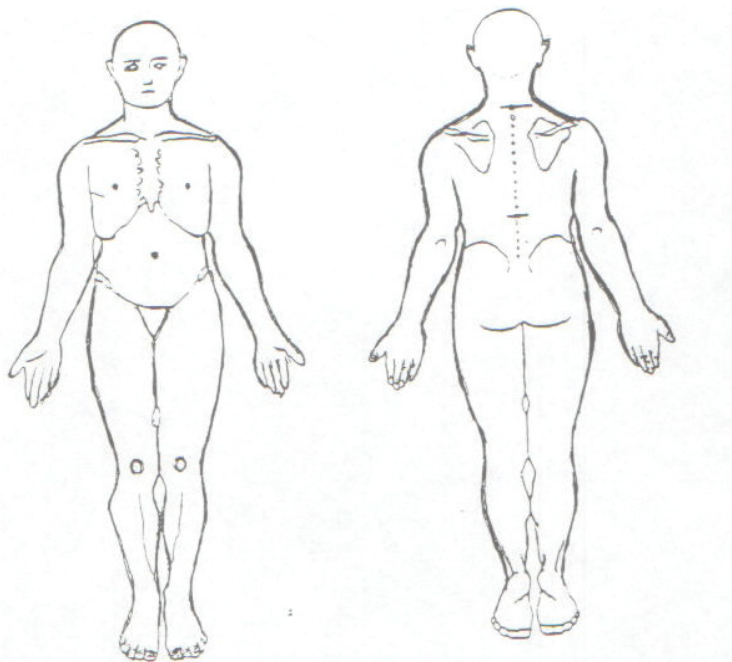
Name: _____ Date: _____ Visit #: _____

FUNCTIONAL STATUS QUESTIONNAIRE

The following information lets us know how you are doing **TODAY**. Please complete this **3 PAGE** questionnaire. We understand that by limiting your responses to how you are today, we may be catching you on a particularly good or bad day.

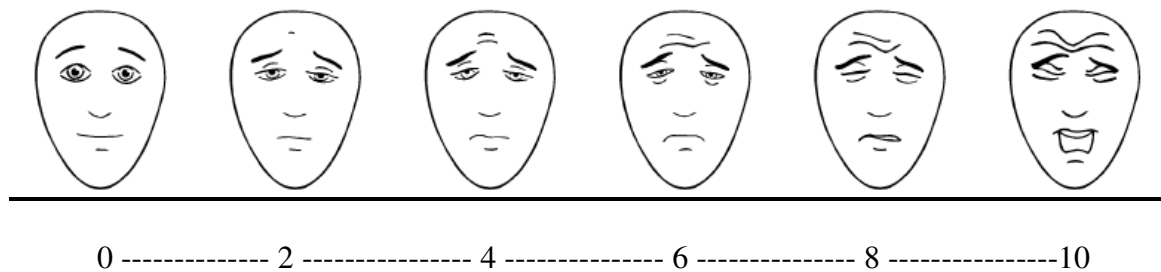
Pain diagram

Draw with / marks on the figures below where you feel pain **TODAY**. Use X marks to show where you feel numbness, tingling, or pins and needles **TODAY**.



Visual Analog Scale

Circle the face corresponding to the amount of pain you feel **TODAY**. These faces show how much pain you are experiencing. The face on the far left indicates no pain. The faces show increasingly more pain up to the one on the far right, which is the worse pain. Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.'



OPTIMAL

(Outpatient Physical Therapy Improvement in Movement Assessment Log)

Difficulty Instrument (effort, struggle, exertion)

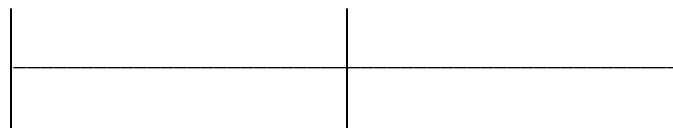
Name: _____ Date: _____ Visit #: _____

Instructions: Please circle the level of <i>difficulty</i> you have for each activity TODAY .	Able to do without any difficulty	Able to do with little difficulty	Able to do With moderate difficulty	Able to do With much difficulty	Unable to do	Not Applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving- lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking- short distance	1	2	3	4	5	9
10. Walking-long distance	1	2	3	4	5	9
11. Walking-outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. From the above list, choose 3 activities you would most like to be able to do *without any difficulty*. For example, if you would most like to be able to *climb stairs, kneel, and squat*, without any difficulty, you would choose: 1. 12 2. 8 3. 5. List the activities in prioritized order of importance to you.

1. _____ 2. _____ 3. _____

23. Thinking about *all* of the activities you would like to do, please mark an **X** at the point on the line that best describes your *overall* level of difficulty with these activities.



I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

For Office Use Only: _____ = trunk subscale
 _____ = lower extremity subscale
 _____ = upper extremity subscale

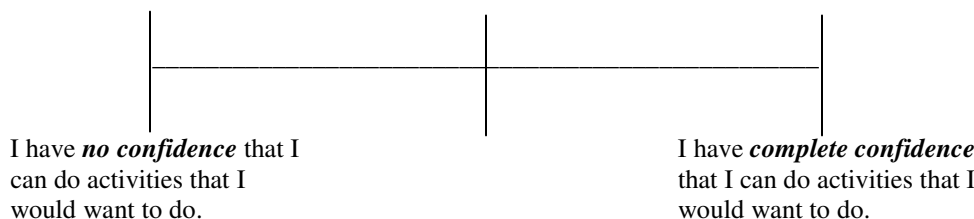
Score: _____
 Score: _____
 Score: _____
 Total: _____

OPTIMAL
 (Outpatient Physical Therapy Improvement in Movement Assessment Log)
Confidence Instrument
 (certainty, trust, belief)

Name: _____ **Date:** _____ **Visit #:** _____

Instructions: Please circle the level of confidence you have for doing each activity TODAY.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving- lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking- short distance	1	2	3	4	5	9
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17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking of *all* the activities you like to do, please mark a **X** at the point on the line that best describes your *overall* level of **confidence** in performing these activities today:



For Office Use Only: _____ = trunk subscale	Score: _____
_____ = lower extremity subscale	Score: _____
_____ = upper extremity subscale	Score: _____
	Total: _____