PATIENT INITIALS:_____ CONROY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY

PATIENT SPECIFIC FUNCTIONAL SCALE

Please list up to 3 important activities that you are unable to do or are having pain or difficulty performing as a result of your problem.

1._____

Activity

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Unable to perform								Able to perform as before injury		

0	1	2	3	4	5	6	7	8	9	10
No pain								Worst pain possible		

2._____

Actvity

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Unable to perform								Able to perform as before injury		

0	1	2	3	4	5	6	7	8	9	10
No pain								Worst pain possible		

3._____

Activity

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Unable to perform								Able to perform as before injury		

0	1	2	3	4	5	6	7	8	9	10
No pain								Worst pain possible		

What is your goal in receiving physical therapy treatment?

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