

MULTIPLE REGION FUNCTIONAL CAPACITY

Name: _____ Date: _____ Age: _____

Patient: Fill out sections 1 to 10. In each category, check one box that best applies your current condition.

1. CURRENT PAIN INTESNITY

<input type="checkbox"/>	I have no pain currently
<input type="checkbox"/>	I have occasional pain which mildly disturbs me at work and home.
<input type="checkbox"/>	I have frequent annoying pain with an occasional pain that slow me down
<input type="checkbox"/>	I have frequent, moderate level, pain and occasional severe pain that stops me from performing more strenuous activities.
<input type="checkbox"/>	I have some degree of pain at all times, with frequent bouts of severe pain which prevents my performing of many normal activities
<input type="checkbox"/>	I have pain all of the time, mostly severe, which I am unable to do most activities for myself. Medications don't help.

2. WORK ABILITY

<input type="checkbox"/>	I am able to currently work full time with no pain.
<input type="checkbox"/>	I work full time and have slight (annoying) symptoms which occasionally may slow me down thus taking slightly longer.
<input type="checkbox"/>	I work full time. My work output quality and/or quantity are reduced 10-20%. Symptoms vary from a slight to moderate levels which cause intermittent halting. I require assistance occasionally at work.
<input type="checkbox"/>	I am able to work part time. I am not able to work at normal pace beyond two hours and at a slower pace beyond four hours. My performance output quality and/or quantity are reduced 30 to 60%.
<input type="checkbox"/>	I am able to work part time. I am not able to work at normal pace for more than 30-60 minutes at a time. I can work at a slower pace beyond two hours. My ability to perform in output is reduced by over 70%.
<input type="checkbox"/>	I am not able to work at a normal or slower pace at all. Job quality and/or quantity are reduced more than 90%. Unable to work on part-time status even with a flexible work schedule.

3. SPORTS, HOBBIES, AND SOCIAL ACTIVITIES

<input type="checkbox"/>	I can perform normal sports, hobby activities, and social activities with my friends, family, or business acquaintances.
<input type="checkbox"/>	My sports, hobby, and social life are normal but pain slows me down occasionally.
<input type="checkbox"/>	Pain or other symptoms limits my more energetic or competitive sports, hobby activities, social activities such as dancing and running.
<input type="checkbox"/>	Severe pain or other symptoms limits moderate energetic sports, hobby, and social activity. I do not go out as often.
<input type="checkbox"/>	Pain or other symptoms limits me to only minimal sports, hobby, and social activity. I usually stay at home.
<input type="checkbox"/>	Unable to participate in any sports, hobby, or social activity due to pain.

4. HOME ACTIVITIES

<input type="checkbox"/>	I can perform normal home activities such as vacuuming, cooking, cleaning, mowing lawn, doing laundry with no pain.
<input type="checkbox"/>	I am able to do all normal home duties but pain slows me down occasionally with very strenuous activities.
<input type="checkbox"/>	Pain prohibits very strenuous home activities. I am able to do lighter to moderate strenuous level home activities.
<input type="checkbox"/>	Severe pain or other symptoms limits moderate and strenuous home activities. I need help doing some activities.
<input type="checkbox"/>	I am able to do only light home activities. I am unable to vacuum floor, do dishes, sweep, mop, and laundry.
<input type="checkbox"/>	I am unable to do any home activities due to pain or other symptoms. I need help putting on clothes and taking bath.

5. SLEEPING

<input type="checkbox"/>	I normally have no difficulty sleeping due to pain or other symptoms.
<input type="checkbox"/>	I have occasional difficulty sleeping due to pain or other symptoms waking up at night resulting in 30 minutes loss of sleep
<input type="checkbox"/>	I have occasional difficulty sleeping due to pain or other symptoms. I loose 10-15% of normal sleeping hours a night.
<input type="checkbox"/>	I have occasional difficulty sleeping due to pain or other symptoms. I am restless most of the night. I lose 25% of hours of sleep a night.
<input type="checkbox"/>	My sleeping hours are reduced about 50%. I usually need medications to sleep well.
<input type="checkbox"/>	I have no normal sleeping hours. I am never able to sleep more than 2-3 hours without heavy medication. I never feel rested.

6. SITTING

<input type="checkbox"/>	I can sit at my desk or drive my car normally with no pain.
<input type="checkbox"/>	I can sit at my desk or drive my car with occasional annoying pain. I need to take breaks on long trips.
<input type="checkbox"/>	Sitting or driving causes frequent annoying pain. Pain becomes severe if sitting for more than 2 hours where I need to change position.
<input type="checkbox"/>	I can sit or drive for 3-4 hours but I need frequent breaks to change my body position. Unable to sit constantly over 1 hour.
<input type="checkbox"/>	I cannot sit or drive for more than 30 minutes at a time due to pain severity.
<input type="checkbox"/>	I cannot sit at my desk, chair at home, or drive my car at any time due to pain severity.

7. UPPER BODY FUNCTION (Neck and arms)

	I am able to use my neck, shoulders, arms and hands in all normal activities with no pain.
	I am able to use my neck, shoulders, arms and hands in all normal activities with occasional annoying pain.
	I am able to lift and move my head and neck, lift arms over my head, reach over my head, carry objects, grip objects with my hand. I have occasional pain when lifting heavy objects over my head which cause me to stop. Occasionally will have difficulty feeling or gripping objects with my hands due to either weakness or numbness. I am limited to light to moderate weights in my hands.
	I am able to lift my arms up to the height of my shoulder for short periods of time but not over my head, carry light to moderate weight objects, grip objects with my hands. I get occasional pain when lifting heavy objects over my head. Occasionally will have difficulty typing, feeling, or gripping objects with my hands due to weakness or numbness. I drop objects 2-3 times a week. I have to use 2 hands for some activities where I could it with one hand before. I am limited to moderate weights.
	I am able carry and grip light objects only. I get frequent pain when lifting any objects over my waist and sometimes am unable to lift to the height of my shoulder. I am unable to lift my arms to the height of my shoulder and lift over my head. I frequently have difficulty feeling or gripping objects with my hands due to either weakness or numbness. I drop objects daily unless I am very careful. I have to use two hands for most activities where I could it with one hand before. I have frequent difficulty typing, using the computer, and writing letters. I am limited to light weights. I have lost 75% of hand lifting ability.
	I am able to lift my arms to the level of my shoulders only and just lifting my arms above my waist causes severe pain. I am unable to lift any object over the height of my waist. Every time I lift my arms up I get severe pain in my neck, shoulders, or arm and I have to lower my arm or arms immediately. I am unable to write letters. I am unable to lift 5 pounds in my hands.

8. LOWER BODY FUNCTION (Low back and legs)

	I can sit, drive, stand, squat, stoop, walk, bend my knees, use my feet, and lift normal heavy weights with no low back/leg pain.
	I can sit, drive, stand, squat, stoop, walk, bend my knees, use my feet, and lift normal heavy weights with occasional annoyance of mild pain. I can do all of these activities but slower if demands are high.
	Moderate levels of low back/leg pain happen if I do prolonged or repeated sitting, driving, standing, stooping, walking, or bending. I can lift heavy objects of positioned properly. Pain limits me to walking ½ mile. Unable to stand for more than 45 minutes at a time. Repeated stooping or bending more than 20 minutes cause me to slow down.
	Moderate to severe levels of low back/leg pain happen if I do prolonged or repeated sitting, driving, standing, stooping, walking, or bending. I can't lift heavy objects at all and am able to lift moderately heavy objects (1/4 my body weight) if properly positioned. Pain limits me to walking ¼ mile. Unable to stand for more than 30 minutes at a time.
	I experiences severe levels of pain if I do short term sitting, driving, standing, stopping, walking or bending. I can't lift moderate or heavy objects at all and am able to lift light objects only (10-15lbs). Need lumbar belt support and/or cane for support to walk. Pain limits me to walking to one block. Unable to stand for more than 10 minutes at a time.
	I experience severe levels of pain if I do sitting, driving, standing, stopping, walking or bending. I am able to walk only with use of cane, crutches or wheelchair. I need to lie down frequently to relieve pain. I am unable to lift or carry any object over five pounds. I need lumbar belt support and/or cane for support to move about in my home. During the daytime I lie down 3-4 hours.

9. HEADACHES

	I have no headaches normally
	I have headaches occasionally which only annoy me at work or at home.
	I have occasional headaches which are intense enough to slow me down at work and home occasionally.
	I have occasional headaches which causes me to stop and rest for short periods of time frequently
	I have frequent headaches which stops all of my activity. I frequently lose time at work or have delays in work production due to pain.
	I have frequent headaches which cause me not being able to go to work, school, home, or participate in recreational activities.

10. MENTAL ABILITY

	My memory and mental function are normal. I have no difficulty with work or home demands.
	I am able to perform most mental activities and am able to function at work, home, and in society. I have occasional slight difficulty with complex tasks, memory, and math.
	I am able to functions normally in most work, home, and society activities. Complex tasks, multiple tasks, and intense concentration tasks are difficult, often resulting in mistakes. I have noticed about a 10-25% memory loss and job performance decline recently.
	I am not able to handle difficult or complex tasks. I have notable memory loss and difficulty making decisions. My friends, family, and I have noticed recent personality changes., It takes much longer to do work and home tasks. I can handle one simple task at a time. I have to write down my daily tasks to remember. My job performance ratings are poor. I have noticed about 26-50% memory loss and job performance decline recently.
	I am able to handle only simple tasks one at a time. Unable to keep full time job. My job performance ratings are poor. My reaction times have slowed down a lot. I have notice about a 52-75% memory loss and job performance declined recently.
	I am unable to hold any job at all. I am unable to balance my checkbook and need help. I am unable to shop without a shopping list. I have severe performance difficulties. I am unable to remember instructions.

TOTAL SCORE (1-10) _____ x2= _____