SPINAL FUNCTIONAL ASSESSMENT

Name: ______________________

Date: ______________________

1. Do you find it difficult to turn over in bed? Yes No
2. Do you awaken at night because of your pain? Yes No

   If yes how many times: ____________
3. Can you put on your shoes and socks? Yes No
4. Do you find it difficult to lie down or get up? Yes No
5. Do you have trouble getting up from a chair? Yes No
6. Does someone else do your housework? Yes No
7. Do you walk slowly because of your back/neck pain? Yes No
8. Do you need to use handrail to go up or down the stairs? Yes No
9. Are you able to work? Yes No
10. Do you live alone? Yes No
11. How often during the day do you need to lie down and rest? ______
12. I walk _____ ft. ______block(s) _______miles before needing to rest.
13. I stand for _____ minutes before needing to rest.
14. I can comfortably sit for _____ minutes before needing to change position.
15. My back/neck hurts me for (most, some, none) of the day. (circle one)
16. I have the most amount of pain the (morning, afternoon, evening). (circle one)
17. I have the least amount of pain in the (morning, afternoon, evening). (circle one)
18. State the chief problem you are having today: ____________________________

    ____
19. Do you take any medications for pain? (If yes, please list them below)

    ____
20. On a scale of 0 to 10 (10 being the worst, 0 being the best) how would you rate your level of pain today? _____
21. What goal(s) would you like to achieve from your physical therapy treatments?

    ____

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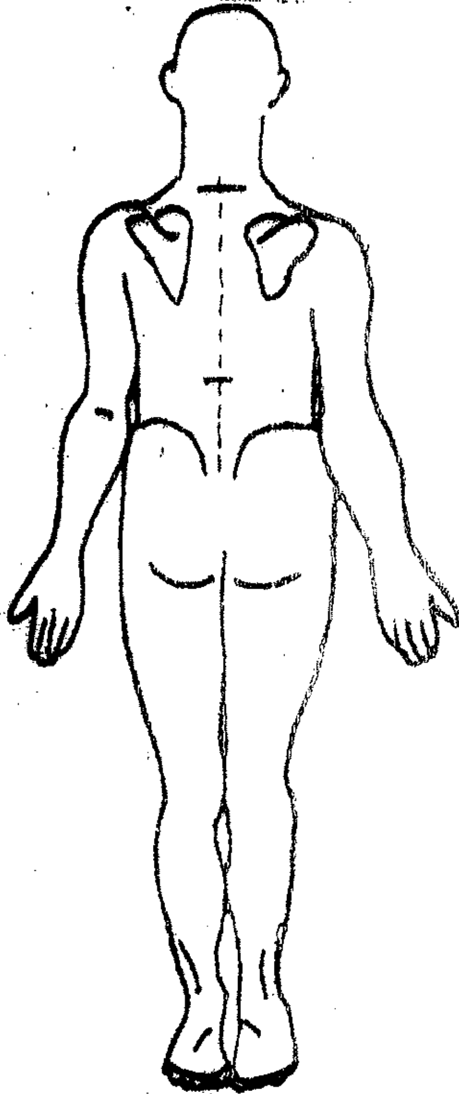

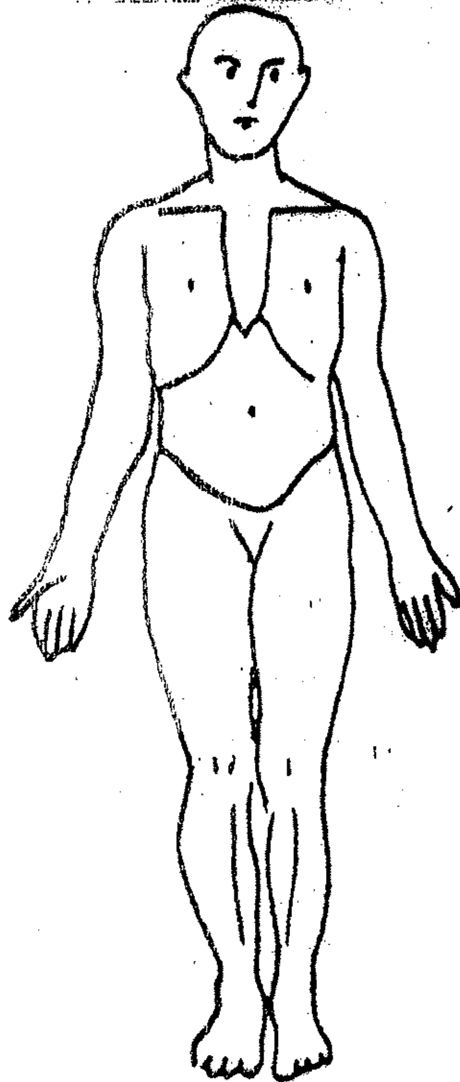

Prior Level of Function:

Prior to exacerbation of pain (date): __________

Sitting:________ minutes

Standing:________ minutes

Walking: __________ minutes

Driving:________ minutes

Any stairs at home? Yes___ No ___

How many steps are needed to climb to enter the house? __________

On what floor is your bedroom located? ___________

How many steps are needed to climb to the second floor? __________

Are there handrails on the staircase? If so, on which side? _________