



PHYSICAL THERAPY SERVICES OF ROCHESTER, P.C.

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Name: _____ Date: _____

We are interested in knowing whether you are having any difficulty at all with the activities listed below. Please circle an answer for each activity:

Extreme Difficulty Or Unable to Perform Activity (0) to No Difficulty (4)

1. Any of your usual work, household, or school activities	0	1	2	3	4
2. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3. Lifting a bag of groceries to waist level	0	1	2	3	4
4. Lifting a bag of groceries above your head	0	1	2	3	4
5. Grooming your hair	0	1	2	3	4
6. Pushing up on your hands (e.g., from bathtub or chair)	0	1	2	3	4
7. Preparing food (e.g., peeling, cutting)	0	1	2	3	4
8. Driving	0	1	2	3	4
9. Vacuuming, sweeping, or raking	0	1	2	3	4
10. Dressing	0	1	2	3	4
11. Doing up buttons	0	1	2	3	4
12. Using tools or appliances	0	1	2	3	4
13. Opening doors	0	1	2	3	4
14. Cleaning	0	1	2	3	4
15. Tying or lacing shoes	0	1	2	3	4
16. Sleeping	0	1	2	3	4
17. Laundering clothes (eg. washing, ironing, folding)	0	1	2	3	4
18. Opening a jar	0	1	2	3	4
19. Throwing a ball	0	1	2	3	4
20. Carrying a small suitcase with your affected limb	0	1	2	3	4

Score: _____/80