Physical Therapy Services

Functional Checklist Activities

Patient's Name:_________________________ Age:____________________________

Diagnosis:_____________________________ Date:___________________________

Please **mark the appropriate number** in the following columns as well as **list the amount of time** it takes you to complete, based on your ability to perform the tasks.

1=Can perform Independently
2=Can perform but is painful
3=Can perform but takes increased time(vs. previous)
4=Can perfrom but requires assistive device or task modification
5=Can partially perfrom but requires assistance of someone
6=Unable to perfom at all

Activities of Daily Living

Activity								Activity							
Household duties:								***Driving***							
Vacuuming	1	2	3	4	5	6	N/A	Shifting Gears	1	2	3	4	5	6	N/A
Washing dishes	1	2	3	4	5	6	N/A	Holding Steering Wheel	1	2	3	4	5	6	N/A
Laundry	1	2	3	4	5	6	N/A	Checking blind spots	1	2	3	4	5	6	N/A
Clean bathroom	1	2	3	4	5	6	N/A	Getting out of a car	1	2	3	4	5	6	N/A
Dusting	1	2	3	4	5	6	N/A	Getting into a car	1	2	3	4	5	6	N/A
Trouble getting up from/out of:								Brake to Gas	1	2	3	4	5	6	N/A
Bed	1	2	3	4	5	6	N/A	Gas to brake	1	2	3	4	5	6	N/A
Floor	1	2	3	4	5	6	N/A	***Sanitary Procedures***							
Chair	1	2	3	4	5	6	N/A	Self Care/Wiping	1	2	3	4	5	6	N/A
Toilet	1	2	3	4	5	6	N/A	Femine Procedures	1	2	3	4	5	6	N/A
Trouble getting down to:								Showering/bathing	1	2	3	4	5	6	N/A
Bed	1	2	3	4	5	6	N/A	Brushing teeth	1	2	3	4	5	6	N/A
Floor	1	2	3	4	5	6	N/A	Combing Hair	1	2	3	4	5	6	N/A
Chair	1	2	3	4	5	6	N/A	Drying Hair	1	2	3	4	5	6	N/A
Toilet	1	2	3	4	5	6	N/A	Washing hair	1	2	3	4	5	6	N/A
Standing	1	2	3	4	5	6	N/A	Looking to Left	1	2	3	4	5	6	N/A
Bending	1	2	3	4	5	6	N/A	Looking to Right	1	2	3	4	5	6	N/A
Throwing	1	2	3	4	5	6	N/A	Looking up	1	2	3	4	5	6	N/A
Cooking								Looking down	1	2	3	4	5	6	N/A
Reaching for pots/pans	1	2	3	4	5	6	N/A	Lifting	1	2	3	4	5	6	N/A
Holding pots/pans	1	2	3	4	5	6	N/A	Sitting up	1	2	3	4	5	6	N/A
Reaching for ingredients	1	2	3	4	5	6	N/A	Laying down	1	2	3	4	5	6	N/A
Balance:								***Reaching***							
On 1 leg	1	2	3	4	5	6	N/A	Up	1	2	3	4	5	6	N/A
On 2 legs	1	2	3	4	5	6	N/A	Down	1	2	3	4	5	6	N/A
Sleeping:								Out to side	1	2	3	4	5	6	N/A
On side	1	2	3	4	5	6	N/A	Squatting	1	2	3	4	5	6	N/A
On back	1	2	3	4	5	6	N/A	Walking	1	2	3	4	5	6	N/A
On stomach	1	2	3	4	5	6	N/A	Stairs	1	2	3	4	5	6	N/A
Putting on/Taking off Clothes:								Steps	1	2	3	4	5	6	N/A
Buttoning/unbuttoning	1	2	3	4	5	6	N/A	Running	1	2	3	4	5	6	N/A
Inserting/removing arm(s)	1	2	3	4	5	6	N/A	Jogging	1	2	3	4	5	6	N/A
Overhead pull on/off	1	2	3	4	5	6	N/A	Yardwork	1	2	3	4	5	6	N/A
Bra on/off	1	2	3	4	5	6	N/A	How long can you tolerate sitting? _______mins/hours							
Pants on/off	1	2	3	4	5	6	N/A	How long can you tolerate standing?______mins/hours							
Socks on/off	1	2	3	4	5	6	N/A	How long can you tolerate walking?_____mins/hours Distance?____							
Tying/Untying Shoes	1	2	3	4	5	6	N/A	***Do you have pain with the following activities?***							
Do you have problems at work? Explain____________________________								Sports ___yes ___no Explain______________________________							
								Sexual Intercourse ___yes ___no Explain_________________________							

Additional Comments:____

Therapist Signature:_______________________________________ **Patient's Signature:**_______________________________________