

**Functional Capacity Evaluation****Name:****Date:**

<b>Walking</b> Pain level 1-10 Constant Intermittent	Distance/surface	Time walked:  Time needed for symptoms to decrease:	Were medications needed to control Pain?  If yes, please list:
<b>Sitting</b> Pain level 1-10 Constant Intermittent	Type of chair:  Time sat:	Time needed for symptoms to decrease:	Were medications needed to control Pain?  If yes, please list (if different than above):
<b>Standing</b> Pain level 1-10 Constant Intermittent	Time stood:  Activity and surface stood upon:	Time needed for symptoms to decrease:	Were medications needed to control Pain?  If yes, please list (if different than above):
<b>Lifting</b> Pain level 1-10 Constant Intermittent	Weight of object lifted:  Height lifted from:  Height lifted to:	Number of times to lift object before pain:  Time for symptoms to decrease:	Are medications needed to control Pain?  If yes, please list (if different that above):
<b>Sleep</b> Pain level 1-10 Constant Intermittent	Number of times awake at night:  Time needed to fall back asleep:	Position you woke up in:	Are medications needed to control Pain?  If yes, please list (if different than above):
<b>Dressing</b> Pain level 1-10 Constant Intermittent	Time needed for pain to decrease:	Are medications needed to dress?	Are medications needed to control Pain?  If yes, please list (if different than above):

<p><b>Mobility:</b> circle all that applies: getting in/out of bed in/out of a chair</p> <p>Pain level 1-10 Constant Intermittent</p>	<p>Number of times you can get up/down from chair:</p>	<p>Time needed for pain to decrease:</p>	<p>Are medications needed to control Pain?</p> <p>If yes, please list (if different than above):</p>
<p><b>Household activities:</b> circle all that apply: dishes, vacuuming, dusting</p> <p>Pain 1-10 Constant Intermittent</p>	<p>Length of time you can do circled activities:</p>	<p>Time needed for pain to decrease:</p>	<p>Are medications needed to control Pain?</p> <p>If yes, please list (if different than above):</p>
<p><b>Writing</b> Pain 1-10 Constant Intermittent</p>	<p>Length of time you can write:</p> <p>Writing instrument:</p>	<p>Time needed for pain to decrease:</p>	<p>Are medications needed to control Pain?</p> <p>If yes, please list (if different than above):</p>
<p><b>Personal care:</b> Shaving, bathing, hair care Pain 1-10 Constant Intermittent</p>	<p>Length of time you can do personal care:</p>	<p>Time needed for pain to decrease:</p>	<p>Are medications needed to control Pain?</p> <p>If yes, please list (if different than above):</p>
<p><b>Driving</b> Pain 1-10 Constant Intermittent</p>	<p>Length of time you can drive:</p> <p>Number of time you can drive a day:</p>	<p>Time needed for pain to decrease:</p>	<p>Are medications needed to control Pain?</p> <p>If yes, please list (if different than above):</p>
<p><b>Keyboarding</b> Pain 1-10 Constant Intermittent</p>	<p>Length of time you can keyboard:</p> <p>Number of keyboarding sessions you can do a day:</p>	<p>Time needed for pain to decrease:</p>	<p>Are medications needed to control Pain?</p> <p>If yes, please list (if different than above):</p>

<b>Headaches</b> Pain 1-10 Constant   Intermittent	Were you asleep and awakened by a headache?  If no what was the activity that induced the headache:	Time need for headache to pass:  Activity you did to alleviate the pain:	Are medications needed to control Pain?  If yes, please list (if different than above):
<b>Stairs</b> Pain 1-10 Constant   Intermittent	Number of times you can go up/down stairs?		Are medications needed to control Pain?  If yes, please list (if different than above):
<b>Uneven ground (walking)</b> Pain 1-10 Constant   Intermittent	Distance you can walk on uneven ground:  Time you were able to walk on uneven ground:	Time needed for symptoms to ease:	Are medications needed to control Pain?  If yes, please list (if different than above):

Please select the activities that affect your pain level and answer the corresponding questions. Try to be as specific as possible about pain levels, rating your pain from 0 (no pain) to 10 (the strongest pain you can imagine). Also, please be specific about the time limits of each activity. If an activity does not affect your symptoms, mark this item N/A (not applicable). This information is important to help facilitate insurance reimbursement as well as evaluate your progress.