

North Star Manual Therapy, Inc.

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Functional Limitations

Name: _____ Date: _____

Do you have problems with any of the following and if so, please be specific.

1. Dressing, grooming, household tasks and/or activities of daily living? _____

2. Difficulty with sleeping? If so, what position do you typically sleep in? _____

3. Problems with driving? Any limitations with turning your head? Any other areas of pain? _____

4. When is your pain the worst? Morning, Evening, Night time, Progressive during the day, or after a specific activity? _____

5. Sitting for prolonged periods of time or certain positions? If so, how long can you sit?

6. Standing for prolonged periods? _____

Where do you hurt when you stand? _____

7. Walking long distances? How far can you walk? Where do you hurt? _____

8. Are you able to function in your occupation or sport? If not, what do you think you should be able to do without pain? _____

9. Do you have pain when you bend over? _____ Do you have pain when you straighten up? _____

10. Can you lift and push/pull or perform overhead activities? _____

11. Do transitional positions bother you? (ie sit-stand, supine-stand) _____

12. Can you squat, kneel, run, jump, or go up and down stairs without pain? _____