SHADY GROVE
PHYSICAL THERAPY
& REHAB CENTER

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UPPER QUARTER FUNCTION FORM

Name: _____ Physician: _____ DOB:_____ Date:_____

In the boxes below, check the number that indicates your level of pain or difficulty when performing these tasks. A 5-Point scale is indicated, with 0=easy to perform, 5= hard to perform, N/A= not applicable.

DRESSING/GROOMING	**0 EASY**	**1**	**2**	**3**	**4 HARD**	**5 UNABLE**	**N/A**
Can you put on/take off your coat?							
Can you fasten your bra?							
Can you fix your hair?							
Can you wash/shave under your opposite arm?							
Can you reach into back pocket or tuck in your shirt?							
HOUSEHOLD AND YARD WORK	**O EASY**	**1**	**2**	**3**	**4 HARD**	**5 UNABLE**	**N/A**
Can you push a vacuum, lawn mower , etc?							
Can you lift a gallon of milk out of the refrigerator or lift a frying pan?							
Can you reach into the top cupboard?							
Can you open a jar?							
NIGHT TIME	**O EASY**	**1**	**2**	**3**	**4 HARD**	**5 UNABLE**	**N/A**
Can you sleep through the night?							
Can you lie on involved side?							
DRIVING	**O EASY**	**1**	**2**	**3**	**4 HARD**	**5 UNABLE**	**N/A**
Can you turn/hold steering wheel or shift gears?							
Can you look behind you when backing up or changing lanes?							
Can you put on your seatbelt/shoulder harness?							
WORK	**O EASY**	**1**	**2**	**3**	**4 HARD**	**5 UNABLE**	**N/A**
Do you have any limitations at work?							

If you have limitations at work, what are they? _____

What recreational activities can you *not* do because of your injury / Illness? _____

How else has this injury/illness affected you? _____

What is the most important thing that you want to work on in physical therapy?

_____

RATE YOUR PAIN LEVEL (Place X on the following line)

No Pain 0 _____ **10 Excruciating**