SPINE AND SPORTS CENTER
OF CHICAGO

Patient Name________________ Date:________________

- **Patient Specific Functional Scale (PSFS):**
  "Identify **3** activities that you are not able to do or have difficulty with as a result of your problem.
  (Write the activity that you are having trouble with in the space provided below (e.g. running, sitting, standing, etc.) Then circle the number that corresponds to that activity.

1.) How difficult is ____________ *for you?*
Activity

0 1 2 3 4 5 6 7 8 9 10
(Unable to perform) (Able to perform fully)

2.) How difficult is ____________ *for you?*
Activity

0 1 2 3 4 5 6 7 8 9 10
(Unable to perform) (Able to perform fully)

3.) How difficult is ____________ *for you?*
Activity

0 1 2 3 4 5 6 7 8 9 10
(Unable to perform) (Able to perform fully)

- **Pain Limitation:** "Over the past 24 hours, how much has your pain limited you from performing any of your normal daily activities?"

0 1 2 3 4 5 6 7 8 9 10
(Activities severely limited) (Activities not limited)

- **Pain Intensity:** "Over the past 24 hours, how bad has your pain been?"

0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Pain as bad as it can be)