

Name- _____

Date- _____

Patient Specific Function Scale

List 3 items that you are unable to perform or have difficulty with. Mark with an "X" the degree of difficulty from zero to ten (with zero being unable to perform activity and 10 being able to perform the activity at a pre-injury level).

1. _____

Please rate how difficult it is for you to perform this item

0	10

Unable to Perform	Able to Perform at Pre-injury Level

2. _____

Please rate how difficult it is for you to perform this item

0	10

Unable to Perform	Able to Perform at Pre-injury Level

3. _____

Please rate how difficult it is for you to perform this item

0	10

Unable to Perform	Able to Perform at Pre-injury Level