

REVISED PATIENT SPECIFIC FUNCTIONAL SCALE (PSFS)

FAX (888) 565-4225

| | | | |
|--------------------|---------------------|----------------------------------|-----------------------------------|
| Patient Last Name | Patient First Name | Patient ID | Date of Birth (MM/DD/YYYY) / / |
| Provider Last Name | Provider First Name | Provider Phone (Area code first) | |

Clinician Instructions: Complete after the history and before the exam

Initial Assessment

Ask the patient to list and score at least 3 activities that they are unable to perform or have the most difficulty performing, because of their chief complaint.

Follow-up or Discharge Assessment

Ask the patient to score the same activities that they were previously unable to perform, or were having the most difficulty performing, because of their chief complaint.

Patient Specific Activity Scoring scheme (Score one number for each activity for each date):

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|----|----------------------------------|
| 0=Able to perform at the same level As before injury or problem. | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 10=Unable to perform activity |
|---|---|---|---|---|---|---|---|---|---|---|----|----------------------------------|

| ACTIVITY | DIAGNOSIS (ICD- 9 CODE) | DATE: | DATE: | DATE: | DATE: | DATE: |
|----------------------|----------------------------|--------------|--------------|--------------|--------------|--------------|
| 1. | | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) |
| | | | | | | |
| 2. | | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) |
| | | | | | | |
| 3. | | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) |
| | | | | | | |
| 4. | | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) |
| | | | | | | |
| 5. | | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) |
| | | | | | | |
| 6. | | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) | Score (0-10) |
| | | | | | | |
| Average Score | | | | | | |

I understand that the information I have provided above is current and complete to the best of my knowledge.

Clinician Signature: _____ Date: _____