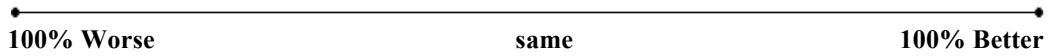
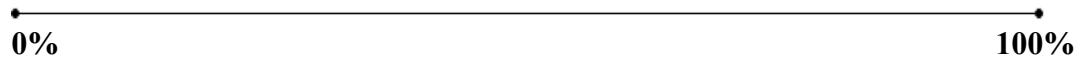


9. Put a slash mark on the line below to indicate how your **FUNCTIONAL MOBILITY** has changed.



10. On the lines below, place a slash mark to indicate your daily functional ability as a percentage of normal.

On a “good day”



On a “bad day”



11. For each activity list below, please note the amount of time in minutes or hours that you can perform before you feel that you need to stop because of your symptoms. If you have no difficulty with the activity, mark OK. If you are unable to perform the activity, mark UNABLE. If this does not apply to you, mark N/A.

Activity	Tolerance	Activity	Tolerance
Sitting		Computer work	
Standing		Exercise	
Walking		Writing	
Stairs(# of stairs)		Shopping	
Driving		Bending	
Sleeping		Reaching (reps)	
Lifting (pounds)		Carrying (pounds)	
Housework			

12. Please list your SHORT TERM GOALS.

13. Please list your LONG TERM GOALS.

14. Please list any specific techniques that have been most effective for your treatment.

15. Please list any specific techniques that have been least effective for your treatment.

16. What activities are you consistently doing for your home exercise program?

17. How often are you doing your home exercise program?

BODY DIAGRAM

