PERFORMANCE PHYSICAL THERAPY AND SPORTS REHABILITATION

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Upper Extremity Functional Index

Patient Name: _____ Date: _____

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have the difficulty at all with: (*Circle **one** number on each line*)

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate Difficulty	A little bit of difficulty	No difficulty
Any of your usual work, housework, or school activities	0	1	2	3	4
Your usual hobbies, recreational or sporting activities	0	1	2	3	4
Lifting a bag of groceries from the floor	0	1	2	3	4
Lifting a bag of groceries above your head	0	1	2	3	4
Grooming your hair	0	1	2	3	4
Pushing up on your hands (e.g., from bathtub or chair)	0	1	2	3	4
Preparing food (e.g., Peeling, cutting)	0	1	2	3	4
Driving	0	1	2	3	4
Vacuuming, sweeping, or raking	0	1	2	3	4
Dressing	0	1	2	3	4
Doing up buttons	0	1	2	3	4
Using tools or appliances	0	1	2	3	4
Opening doors	0	1	2	3	4
Cleaning	0	1	2	3	4
Tying or lacing shoes	0	1	2	3	4
Sleeping	0	1	2	3	4
Laundering clothes (e.g., Washing, ironing folding)	0	1	2	3	4
Opening a jar	0	1	2	3	4
Throwing a ball	0	1	2	3	4
Carrying a small suitcase with your affected limb	0	1	2	3	4
Column Total					

The Therapist will total all the columns

Score: ___/80

Pain Scale: Please place **TWO** circles on the scale below, one for your pain level at its worst in the last 48 hours and the other for your pain level at its best in the last 48 hours. (If you have had instances of no pain, circle 0 for best)

0 1 2 3 4 5 6 7 8 9 10

0 = No pain 5 = Makes you stop what you are doing 10 = Worst Pain imaginable, need to go to ER