Name _____ Date _____ Patient ID#_____

Upper Extremity Functional Scale

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

Today, do you or would you have any difficulty 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
a. Any of your usual work, household, or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
c. Lifting a bag of groceries to waist level.	0	1	2	3	4
d. Lifting a bag of groceries above your head.	0	1	2	3	4
e. Grooming your hair.	0	1	2	3	4
f. Pushing up on your hands (e.g., from bathtub or chair).	0	1	2	3	4
g. Preparing food (e.g., peeling, cutting).	0	1	2	3	4
h. Driving.	0	1	2	3	4
i. Vacuuming, sweeping, or raking.	0	1	2	3	4
j. Dressing.	0	1	2	3	4
k. Doing up buttons.	0	1	2	3	4
l. Using tools or appliances.	0	1	2	3	4
m. Opening doors.	0	1	2	3	4
n. Cleaning.	0	1	2	3	4
o. Tying or lacing shoes.	0	1	2	3	4
p. Sleeping.	0	1	2	3	4
q. Laundering clothes (e.g., washing, ironing, folding).	0	1	2	3	4
r. Opening a jar.	0	1	2	3	4
s. Throwing a ball.	0	1	2	3	4
t. Carrying a small suitcase with your affected limb).	0	1	2	3	4
COLUMN TOTALS (for physical therapist use)					

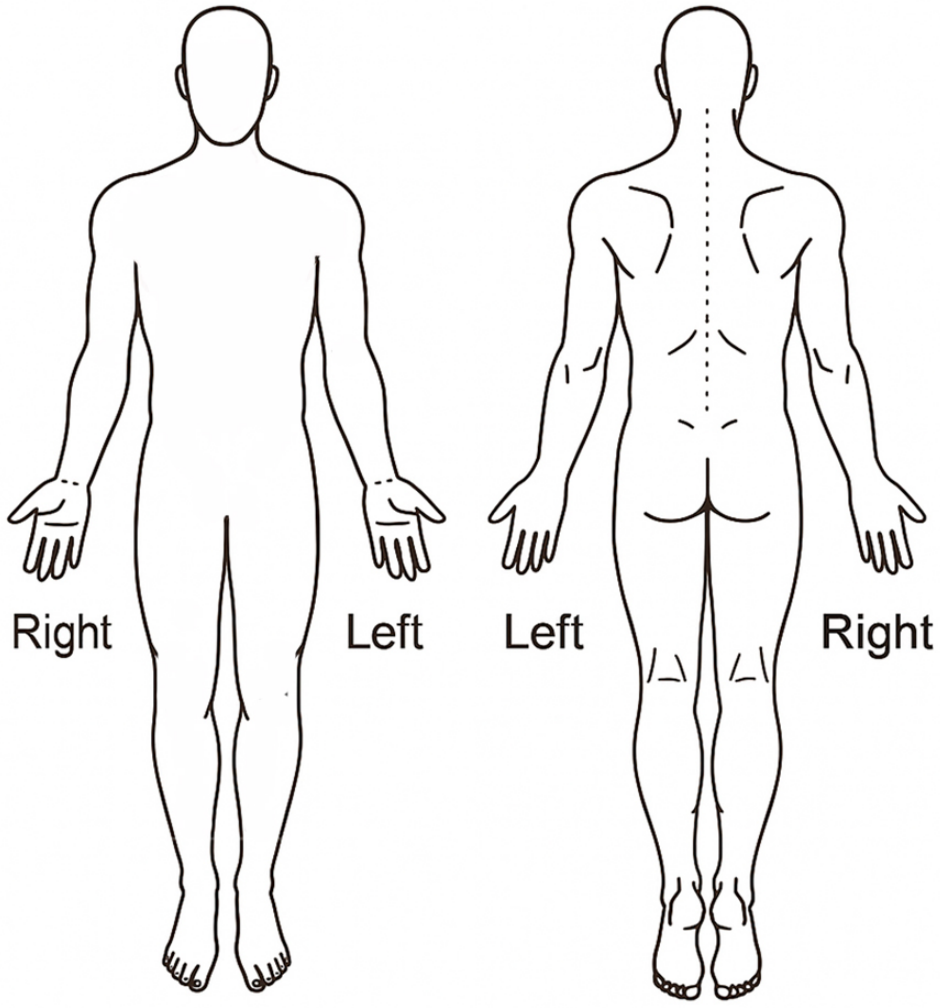
Score is the sum of all circled items. (range = 0-80)

Score: ___/80

Patient Name: _____ Date: _____ / _____ / _____

Instructions:

On the body diagram below, please indicate where your symptoms are located at the present time.



Please rate your pain on a scale from 0 (no pain) to 10 (worst pain imaginable)

present: _____ lowest: _____ highest: _____

over the past 30 days:

Please briefly describe when your symptoms began, cause (if known), what makes you better and worse, treatment received, and any goals you may have for physical therapy.

_____

_____

_____

_____