

**REVISED PATIENT SPECIFIC FUNCTIONAL SCALE (PSFS)**

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
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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)
<b>Average Score</b>						

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

Clinician Signature: \_\_\_\_\_

Date: \_\_\_\_\_