Functional Capacity Evaluation **Name:** **Date:**

Walking Pain level 1-10 Constant Intermittent	Distance/surface	Time walked: Time needed for symptoms to decrease:	Were medications needed to control Pain? If yes, please list:
Sitting Pain level 1-10 Constant Intermittent	Type of chair: Time sat:	Time needed for symptoms to decrease:	Were medications needed to control Pain? If yes, please list (if different than above):
Standing Pain level 1-10 Constant Intermittent	Time stood: Activity and surface stood upon:	Time needed for symptoms to decrease:	Were medications needed to control Pain? If yes, please list (if different than above):
Lifting Pain level 1-10 Constant Intermittent	Weight of object lifted: Height lifted from: Height lifted to:	Number of times to lift object before pain: Time for symptoms to decrease:	Are medications needed to control Pain? If yes, please list (if different that above):
Sleep Pain level 1-10 Constant Intermittent	Number of times awake at night: Time needed to fall back asleep:	Position you woke up in:	Are medications needed to control Pain? If yes, please list (if different than above):
Dressing Pain level 1-10 Constant Intermittent	Time needed for pain to decrease:	Are medications needed to dress?	Are medications needed to control Pain? If yes, please list (if different than above):

Mobility: circle all that applies: getting in/out of bed in/out of a chair Pain level 1-10 Constant Intermittent	Number of times you can get up/down from chair:	Time needed for pain to decrease:	Are medications needed to control Pain? If yes, please list (if different than above):
Household activities: circle all that apply: dishes, vacuuming, dusting Pain 1-10 Constant Intermittent	Length of time you can do circled activities:	Time needed for pain to decrease:	Are medications needed to control Pain? If yes, please list (if different than above):
Writing Pain 1-10 Constant Intermittent	Length of time you can write: Writing instrument:	Time needed for pain to decrease:	Are medications needed to control Pain? If yes, please list (if different than above):
Personal care: Shaving, bathing, hair care Pain 1-10 Constant Intermittent	Length of time you can do personal care:	Time needed for pain to decrease:	Are medications needed to control Pain? If yes, please list (if different than above:)
Driving Pain 1-10 Constant Intermittent	Length of time you can drive: Number of time you can drive a day:	Time needed for pain to decrease:	Are medications needed to control Pain? If yes, please list (if different than above):
Keyboarding Pain 1-10 Constant Intermittent	Length of time you can keyboard: Number of keyboarding sessions you can do a day:	Time needed for pain to decrease:	Are medications needed to control Pain? If yes, please list (if different than above):

Headaches Pain 1-10 Constant Intermittent	Were you asleep and awakened by a headache? If no what was the activity that induced the headache:	Time need for headache to pass: Activity you did to alleviate the pain:	Are medications needed to control Pain? If yes, please list (if different than above):
Stairs Pain 1-10 Constant Intermittent	Number of times you can go up/down stairs?		Are medications needed to control Pain? If yes, please list (if different than above):
Uneven ground (walking) Pain 1-10 Constant Intermittent	Distance you can walk on uneven ground: Time you were able to walk on uneven ground:	Time needed for symptoms to ease:	Are medications needed to control Pain? If yes, please list (if different than above):

Please select the activities that affect your pain level and answer the corresponding questions. Try to be a specific as possible about pain levels, rating your pain from 0 (no pain) to 10 (the strongest pain you can imagine). Also, please be specific about the time limits of each activity. If an activity does not affect your symptoms, mark this item N/A (not applicable). This information is important to help facilitate insurance reimbursement as well as evaluate your progress.