

Functional Rating Index

MAIN COMPLAINT: _____

In order to properly assess you condition, we must understand how much you main compliant has affected your ability to manage everyday activities.

For each item below, please circle the one choice which most closely describes your condition right now.

1. Pain Intensity

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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2. Sleeping

Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep
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3. Personal Care (washing, dressing)

No pain no restriction	Mild pain no restriction	Moderate pain; need to go slowly	Moderate pain; need some assistance	Severe pain; need 100% assistance
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4. Travel (driving, etc)

No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips
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5. Work

Can do usual work plus unlimited extra work	Can do usual work no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work
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6. Recreation

No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain
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7. Frequency of Pain

No pain	Occasional pain; 25% of the day	Intermittent pain; 50% of day	Frequent pain 75% of the day	Constant pain 100% of the day
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8. Lifting

No pain w/heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight
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9. Walking

No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with all walking
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10. Standing

No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing
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Name _____

PRINTED

Signature

Date

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