**SOUTHERN IDAHO THERAPY SERVICES**

Low Back Functional Index

**Section 1: To be completed by patient**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many days ago did onset/injury occur? \_\_\_\_\_\_

**Section 2: To be completed by patient**

This questionnaire has been designed to give your therapist information as to how your Low Back has affected your ability to manage in everyday life. Please answer every question by placing a mark on the line that best describes your condition today. We realize you may feel that two of the statements may describe your condition, but ***please mark only the line which most closely describes your current condition.***

**WALKING**

 🞏 Symptoms do not prevent me from walking any distance.

 🞏 Symptoms prevent me walking more than 1 mile.

 🞏 Symptoms prevent me walking more than ½ mile.

 🞏 Symptoms prevent me walking more than ¼ mile.

 🞏 I can only walk using a stick or crutches.

 🞏 I am in bed most of the time and have to crawl to the toilet.

**WORK** *(Applies to work in home and outside)*

 🞏 I can do as much work as I want to.

 🞏 I can only do my usual work, but no more.

 🞏 I can do most of my usual work, but no more.

 🞏 I cannot do my usual work.

 🞏 I can hardly do any work at all (only light duty).

 🞏 I cannot do any work at all.

**PERSONAL CARE** *(Washing, Dressing, etc.)*

 🞏 I can manage all personal care without symptoms.

 🞏 I can manage all personal care with some increased symptoms

 🞏 Personal care requires slow, concise movements due to increased symptoms.

 🞏 I need help to manage some personal care.

 🞏 I need help to manage all personal care.

 🞏 I cannot manage any personal care.

**SLEEPING**

 🞏 I have no trouble sleeping.

 🞏 My sleep is mildly disturbed (less than 1 hour sleep loss).

 🞏 My sleep is mildly disturbed (1-2 hours sleep loss).

 🞏 My sleep is moderately disturbed (2-3 hours sleep loss).

 🞏 My sleep is greatly disturbed (3-5 hours sleep loss).

 🞏 My sleep is completely disturbed (6-7 hours sleep loss).

**RECREATION**

 🞏 I am able to engage in all my recreational activities without increased symptoms.

 🞏 I am able to engage in all my recreational activities with some increased symptoms.

 🞏 I am able to engage in most, but not all of my usual recreational activities because of my increased symptoms.

 🞏 I am able to engage in a few of my usual recreational activities because of my increased symptoms.

 🞏 I can hardly do any recreational activities because of increased symptoms.

 🞏 I cannot do any recreational activities at all.

**DRIVING** Section 2 (continued) page 2

 🞏 I can drive my car or travel without any extra symptoms. Lumbar

 🞏 I can drive my car or travel as long as I want with slight symptoms.

 🞏 I can drive my car or travel as long as I want with moderate symptoms.

 🞏 I cannot drive my car or travel as long as I want because of moderate symptoms.

 🞏 I can hardly drive at all or travel because of severe symptoms.

 🞏 I cannot drive my car or travel at all.

**LIFTING**

 🞏 I can lift heavy weights without extra symptoms.

 🞏 I can lift heavy weights but it gives extra symptoms.

 🞏 My symptoms prevent me from lifting heavy weights but I manage if they are conveniently positioned.

🞏 My symptoms prevent me from lifting heavy weights but I manage light to medium weights if they are

 conveniently positioned.

 🞏 I can lift only very light weights.

 🞏 I cannot lift or carry anything at all.

**STANDING**

 🞏 I can stand as long as I want without increased symptoms.

 🞏 I can stand as long as I want, but it gives me extra symptoms.

 🞏 Symptoms prevent me from standing for more than 1 hour.

 🞏 Symptoms prevent me from standing for more than 30 minutes.

 🞏 Symptoms prevent me from standing for more than 10 minutes.

 🞏 Symptoms prevent me from standing at all.

**SQUATTING**

 🞏 I can squat fully without the use of my arms for support.

 🞏 I can squat fully, but with symptoms or using my arms for support.

 🞏 I can squat 3/4 of my normal depth, but less than fully.

 🞏 I can squat 1/2 of my normal depth, but less than 3/4.

 🞏 I can squat 1/4 of my normal depth, but less than 1/2.

 🞏 I am unable to squat any distance due to symptoms.

**SITTING**

 🞏 I can sit in any chair as long as I like.

 🞏 I can only sit in my favorite chair as long as I like.

 🞏 My symptoms prevent me sitting more than 1 hour.

🞏 My symptoms prevent me sitting more than 1/2 hour.

 🞏 My symptoms prevent me sitting more than 10 minutes.

 🞏 My symptoms prevent me from sitting at all.

**Section 3: To be completed by patient**

**PAIN SCALE** – How severe is your pain? Circle the number that best describes your pain: 0 = No pain and 10 = worst imaginable

At its best? 0 1 2 3 4 5 6 7 8 9 10

At its worst? 0 1 2 3 4 5 6 7 8 9 10

Average? 0 1 2 3 4 5 6 7 8 9 10

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***Section 4: To be completed by physical therapist/provider***

SCORE: \_\_\_\_\_\_\_\_\_\_\_% Initial Evaluation

SCORE:\_\_\_\_\_\_\_\_\_\_\_% 10th Visit SCORE:\_\_\_\_\_\_\_\_\_\_\_\_% 20th Visit SCORE: \_\_\_\_\_\_\_\_\_\_% 30th Visit

SCORE:\_\_\_\_\_\_\_\_\_\_\_% Discharge

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