

The Physical Therapy Place, LLC
 Orthopedics and Women's Health
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Patient-Specific Functional Questionnaire (PSFQ)

Patient Name _____ Date of Birth _____ Today's Date _____

Please list in the table below up to **5 activities that are important to you** and that you are **unable to do** or are finding difficult as a result of your current problem.

Activities I currently have difficulty doing or cannot do:	How difficult is it for you to perform this activity? Score: 0=unable to perform activity, 10= able to perform activity at pre-injury/condition level	During your treatment, your PT will check in with you to see how you are progressing with these activities. Please leave the spaces below open for future use.			
		Date & Score	Date & Score	Date & Score	Date & Score
1.					
2.					
3.					
4.					
5.					
TOTAL:					

Thank You!

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