

**Shaul's Individualized Physical Therapy, PC**

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Name: \_\_\_\_\_

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

Please list at least 3 activities (and rate them) you are unable to perform or have most difficulty performing due to your problem.

1. \_\_\_\_\_

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

2. \_\_\_\_\_

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

3. \_\_\_\_\_

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

4. \_\_\_\_\_

0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

**0 = able to perform at the same level as before injury or problem**

**10 = unable to perform activity**