FOTO General
Physical Functioning Assessment

Patient Name: _____ **Date:** _____

Below is a series of statements about your physical ability to perform daily activities. Please read each statements carefully and rate your level of difficulty using the scale provided. Be honest in your responses, as this will help us understand your current physical functioning.

1. **Neck Movements**: Turning your head to look over your shoulder
   Rating: _____

2. **Reaching Overhead**: Reaching for an item on a high shelf
   Rating: _____

3. **Bending**: Bending down to pick up an object from the floor
   Rating: _____

4. **Lifting**: Carrying a bag weighing about 10 pounds
   Rating: _____

5. **Walking**: Walking on a flat surface for 10 minutes
   Rating: _____

6. **Climbing Stairs**: Going up and down a flight of stairs without assistance
   Rating: _____

7. **Sitting**: Sitting for 30 minutes without discomfort
   Rating: _____

8. **Standing**: Standing in one place for 30 minutes without discomfort
   Rating: _____

9. **Reaching Behind**: Reaching behind your back to put on a jacket
   Rating: _____

10. **Getting In and Out of Bed**: Moving from a lying position to a sitting and standing
    Rating: _____

Rating Scale

0: Unable to do

1: Extreme Difficulty

2: Quite a bit of Difficulty

3: Moderate Difficulty

4: A little by of Difficulty

5: No Difficulty

Scoring

1. Add up the rating of all questions:

Total Score: _____**/50**

Percentage Score: _____**%**

☐ Active

☐ Wellness (If Medicare, ABN Form must be presented & signed by patient before services rendered)

Provider Recommended Treatment Plan: _____

Therapies: **# IT** _____ **#FD** _____ **#PTLMS** _____ **#Wobble** _____ **# Massage** _____

DME (Circle One) **Orthotics / Heel Lift (Size:** _____**)** **TENS Unit** **BaxMaxx (Size:** _____**)** **Other:** _____

Recommended At-Home Therapy/Exercises: _____

Is Patient Being Referred to an Outside Provider? **Yes / No** If yes, list outside provider: _____

Provider's Signature: _____ **Date:** _____