Functional Rating Index

Patient Name: ____________________________________ **Date:** ______________________

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

1. Pain Intensity

0-No pain	1- Mild Pain	2- Moderated Pain	3- Severe Pain	4- Worst Possible Pain

2. Sleeping

0- Perfect sleep	1- Mildly Disturbed	2- Moderately Disturbed	3- Greatly Disturbed	4- Totally Disturbed Sleep

3. Personal Care (washing, dressing, etc.)

0- No pain No Restrictions	1- Mild Pain No Restrictions	2- Moderated Pain Go Slowly	3- Moderate Pain Some Assistance	4- Severe Pain 100% Assistance

4. Traveling (driving, etc.)

0- No pain on Long Trips	1- Mild Pain on Long Trips	2- Moderated Pain on Long Trips	3- Moderate Pain on Short Trips	4- Severe Pain on Short Trips

5. Work

0- Usual Work + Extra	1- Usual Work No extra	2- 50% of Usual Work	3- 25% of Usual Work	4- Cannot Work

6. Recreation

0- All Activities	1- Most Activities	2- Some Activities	3- Few Activities	4- No Activities

7. Frequency of Pain

0- No pain	1- Occasional (25%)	2- Intermittent (50%)	3- Frequent (75%)	4- Constant (100%)

8. Lifting

0- No pain with Heavy Weight	1- Increased Pain with Heavy Weight	2- Increased Pain with Moderate Weight	3- Increased Pain with Light Weight	4- Increased Pain with Any Weight

9. Walking

0- No pain with Any Distance	1- Increased Pain After 1 Mile	2- Increased Pain After ½ Mile	3- Increased Pain After ¼ Mile	4- Increased Pain After Any Distance

10. Standing

0- No pain at Any time	1- Increased Pain After Several Hours	2- Increased Pain After 1 Hour	3- Increased Pain After ½ Hour	4- Increased Pain After Any Time

11. Current Pain Intensity

Please Circle One: 0 1 2 3 4 5 6 7 8 9 10 Worst Possible Pain

Total: __________ (/4 X 10) **= Functional Rating Score** __________%

Patient or Guardian Signature ____ **Date**_______________