

CERVICAL SPINE FUNCTIONAL QUESTIONNAIRE

Please answer each question and choose the response that most accurately describes your functional limitations *as they relate to your CURRENT spinal injury*

Functional Activity	N/A (0)	Never (1)	Seldom (2)	Occasionally (3)	Frequently (4)	Always (5)
I have difficulty dressing (i.e., putting on jacket, pulling shirt overhead)						
I have difficulty bathing or attending to personal hygiene						
I have difficulty gripping objects when writing, cutting food, etc.						
I have difficulty performing work tasks						
I have difficulty preparing meals						
I have difficulty performing daily household, work, or recreational tasks due to <u>headaches</u>						
I have difficulty placing an object overhead (i.e., into a cupboard)						
I have difficulty performing heavy household chores (i.e., cleaning floors and walls)						
I have difficulty carrying a laundry basket, shopping bag, briefcase or handbag						
I have difficulty carrying objects greater than 10 pounds						
I have difficulty washing, brushing, or blow drying hair						
I have difficulty reading						
I have difficulty with gardening or yard work						
I have difficulty performing light recreational activities (i.e., playing cards or knitting)						
I have difficulty performing recreational activities such as golf, tennis, etc.						
I have difficulty driving such as when turning my head to look over my shoulder						
I have difficulty sleeping through the night due to my injury						
I have difficulty with daily tasks due to dizziness or loss of balance related to my injury						
I have difficulty looking up to perform overhead activities						
Total score/column (for therapist use only)						

Total score (for therapist use only): _____ /95

Please note any other functional limitations that were not addressed above: _____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____