Upper Extremity Functional Scale

Name:	Date:

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper extremity problem for which you are currently seeking attention. Please provide an answer for each activity.

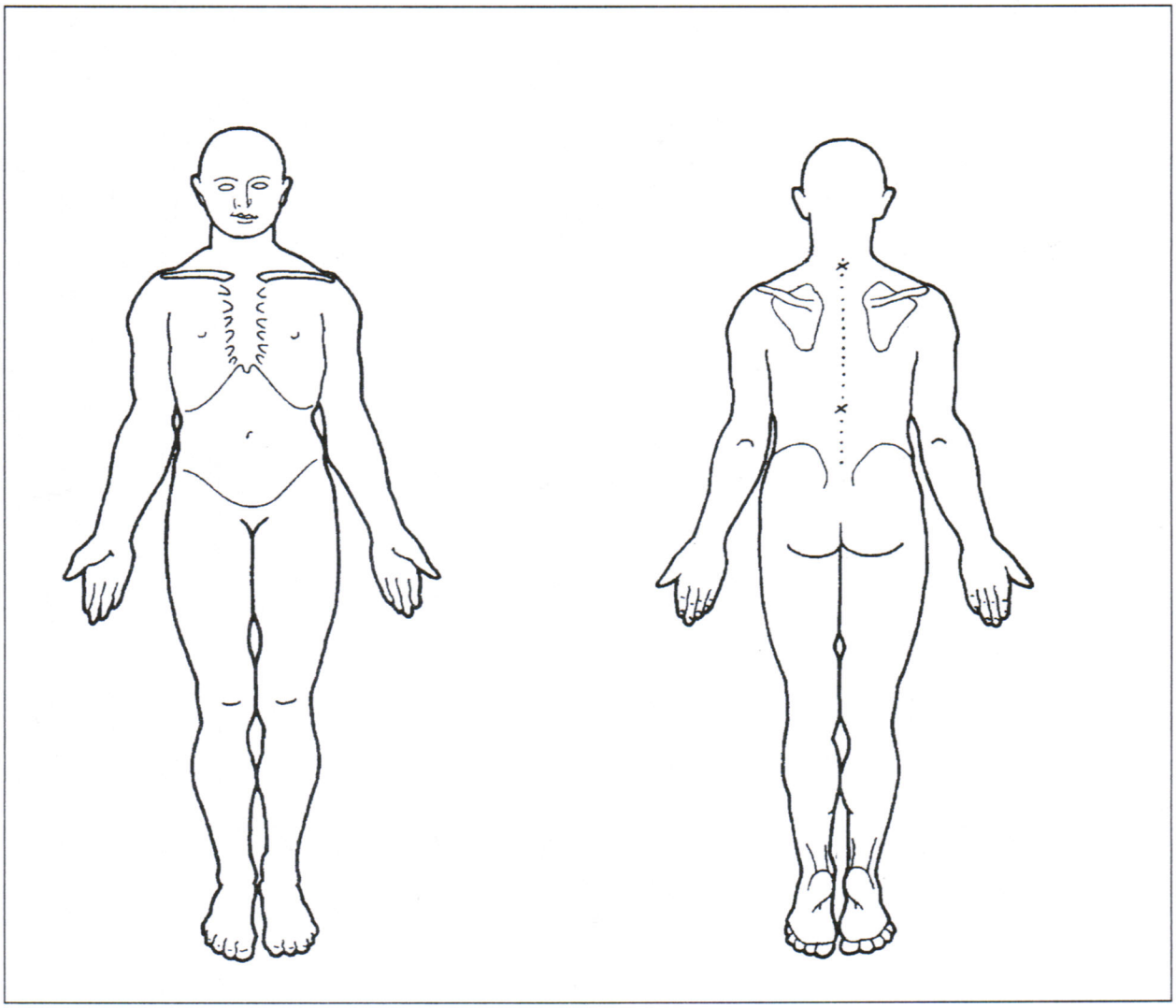
Today, do you or would you have any difficulty at all with:

	Activities	Unable to perform activity or extreme difficulty	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
1	Any of your usual work, housework or school activities	0 ○	1 ○	2 ○	3 ○	4 ◉
2	Your usual hobbies, recreational or sporting activities	0 ○	1 ○	2 ○	3 ○	4 ◉
3	Lifting a bag of groceries to waist level	0 ○	1 ○	2 ○	3 ○	4 ◉
4	Lifting a bag of groceries above your head	0 ○	1 ○	2 ○	3 ○	4 ○
5	Grooming your hair	0 ○	1 ○	2 ○	3 ○	4 ○
6	Pushing up on your hands (e.g. from bathtub or chair)	0 ○	1 ○	2 ○	3 ○	4 ◉
7	Preparing food (e.g. peeling and cutting)	0 ○	1 ○	2 ○	3 ○	4 ◉
8	Driving	0 ○	1 ○	2 ○	3 ○	4 ◉
9	Vacuuming, sweeping or raking	0 ○	1 ○	2 ○	3 ○	4 ○
10	Dressing	0 ○	1 ○	2 ○	3 ○	4 ◉
11	Doing up buttons	0 ○	1 ○	2 ○	3 ○	4 ◉
12	Using tools or appliances	0 ○	1 ○	2 ○	3 ○	4 ◉
13	Opening doors	0 ○	1 ○	2 ○	3 ○	4 ○
14	Cleaning	0 ○	1 ○	2 ○	3 ○	4 ○
15	Tying or lacing shoes	0 ○	1 ○	2 ○	3 ○	4 ◉
16	Sleeping	0 ○	1 ○	2 ○	3 ○	4 ◉
17	Laundering clothes (e.g. washing, ironing, folding)	0 ○	1 ○	2 ○	3 ○	4 ◉
18	Opening a jar	0 ○	1 ○	2 ○	3 ○	4 ○
19	Throwing a ball	0 ○	1 ○	2 ○	3 ○	4 ◉
20	Carrying a small suitcase with your affected limb	0 ○	1 ○	2 ○	3 ○	4 ◉
	Column Totals:					

Total Score: _____ / 80

Name: Signature:
Date:

Please use the drawings below to indicate where you feel symptoms right now.
Shade in all areas where you feel pain.



Please use the three scales below to rate the intensity of your pain over the past **24 hours.** Use the upper number scale to describe your pain right now. Use the middle scale to describe the worst pain you have experienced since this time yesterday. Use the lower scale to describe the least amount of pain you have felt since this time yesterday.

Rate Your Pain	**0= No Pain**										**10= Severe Pain**
Right Now	0	1	2	3	4	5	6	7	8	9	10
Worst in 24 Hours	0	1	2	3	4	5	6	7	8	9	10
Least in 24 Hours	0	1	2	3	4	5	6	7	8	9	10