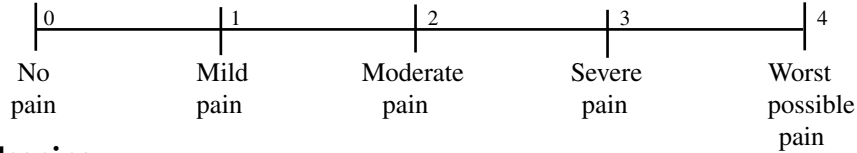


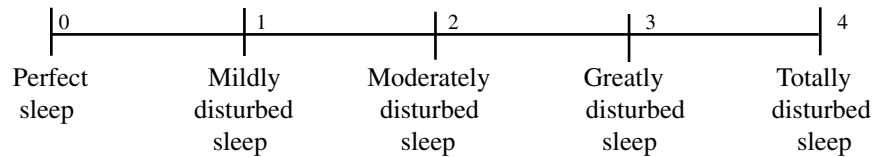
Functional Rating Index

In order to properly assess your condition, we must understand how much your *condition(s)* have affected your ability to manage everyday activities. For each item below, **please circle the number which most closely describes your condition right now.**

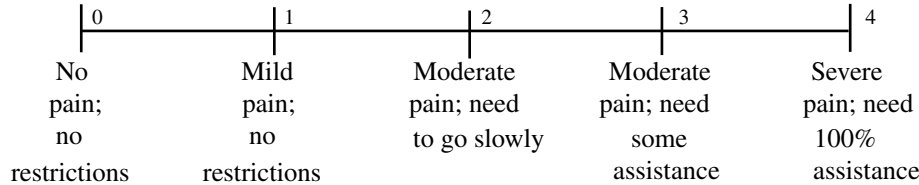
1. Pain Intensity



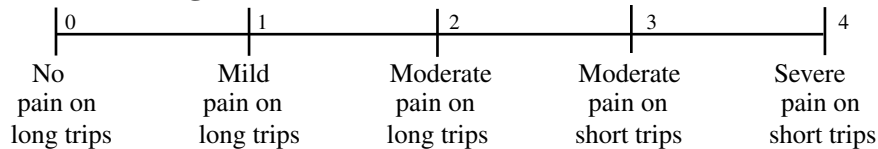
2. Sleeping



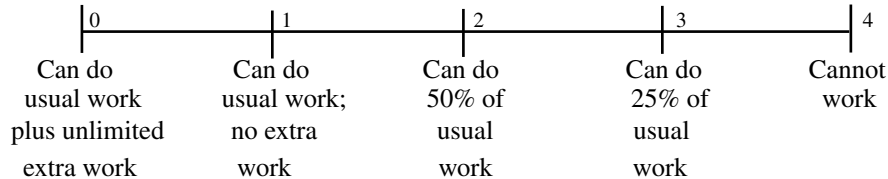
3. Personal Care (washing, dressing, etc.)



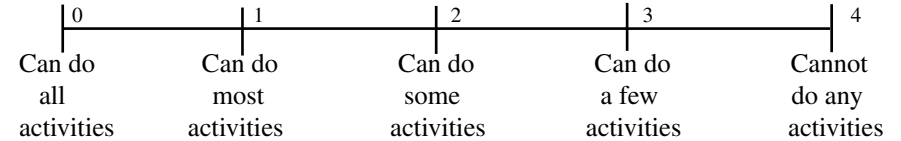
4. Travel (driving, etc.)



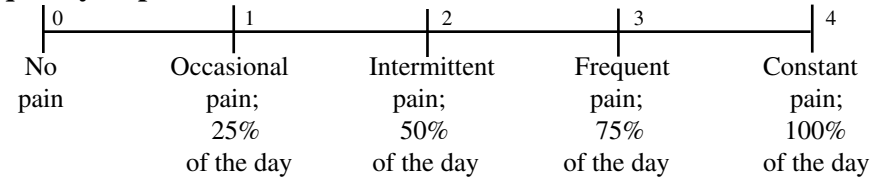
5. Work



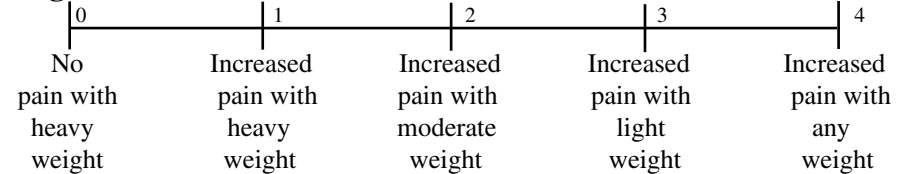
6. Recreation



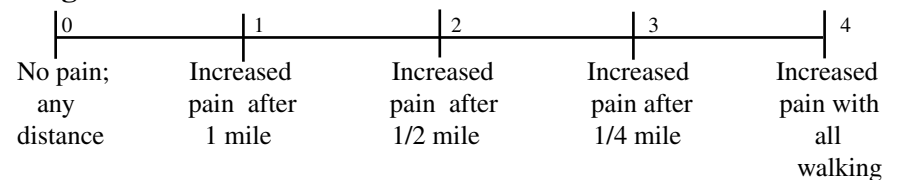
7. Frequency of pain



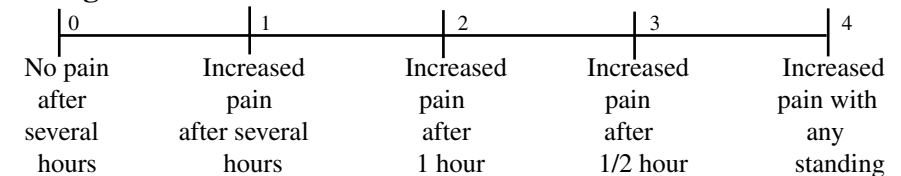
8. Lifting



9. Walking



10. Standing



Patient

PRINTED _____

Signature _____

Doctor

Signature _____

Total Score _____

Date _____