MASSACHUSETTS GENERAL HOSPITAL
BOSTON, MASSACHUSETTS 02114
PHYSICAL THERAPY SERVICES
ACTIVITY QUESTIONNAIRE

LABEL

Tell us whether or not you have difficulty performing the following activities. Please complete this form as best you can by marking YES, NO, or N/A as appropriate.

YES-I do have a problem or have changed the way I do it
NO-I do not have a problem **N/A**-I never do or did this activity

Activity	YES	NO	N/A	Therapist's Use Only
Sleeping through the night				
Getting into/out of bed				
Rolling over in bed				
Getting into/out of tub/shower				
Showering/Bathing				
Grooming				
Dressing upper body				
Dressing lower body				
Putting on shoes and socks				
Combing/brushing hair				
Preparing meals				
Eating/feeding yourself				
Housekeeping				
Yard work				
Standing for extended periods				
Sitting for extended periods				
Getting up from chairs in your home and/or at work				
Reaching objects on high shelves/cabinets				
Picking up objects from the floor				
Climbing stairs without a rail				
Going up/down curbs				
Getting into/out of a car				
Driving				
Riding in a car				
Using public transportation				
Opening/closing doors				
Going into/out of stores				
Carrying groceries, trash, laundry, luggage				
Walking on level ground				
Walking on uneven ground/sidewalks				
Getting up/down from the floor				

OVER -->

ACTIVITY QUESTIONNAIRE

YES-I do have a problem or have changed the way I do it **NO** I do not have a problem **N/A-**I never do or did this activity

Activity	YES	NO	N/A	Therapist's Use Only
LEISURE ACTIVITIES				
Computer work				
Watching television				
Reading				
Watching movies/theater				
Gardening or lawnwork				
Other:				
SPORTS (individual)				
Golf				
Jogging/running				
Swimming				
Work-outs				
Other:				
Sports (group/team) List applicable activities				
Social/Family Roles				
Caring for family member(s)				
Getting into/out of homes of family/friends				
Getting into/out of restaurants as desired				
Attending religious ceremonies as desired				
Participating in social activities				
Other activities:				

WORK RELATED ACTIVITIES

Are you currently employed? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

If NO, are you: ☐ Retired ☐ Disabled ☐ Unemployed ☐ Not working outside of the home by choice

If you are out of work, is it because of the problem for which you are coming to PT?

☐ Yes ☐ No

If you are working, what is your job/role? _____

Are you currently able to perform all of your job requirements? ☐ Yes ☐ No

Therapist's Signature: _____ Date: _____