FUNCTIONAL RECOVERY QUESTIONNAIRE

Provider Name: _____
(Print)

Provider #ID (L&I or NPI): _____

Patient Name:

Date of Injury: __ __ / __ __ / _ _ _ _
m m d d y y y y

Claim #:

Today's Date: __ __ / __ __ / _ _ _ _
mm dd year

To be completed by patient currently off work.

For office use

▼

☐ N = ✓

☐ ≥ 5= ✓

☐ = ✓

OR

☐ ≥2 = ✓

_____ Total ☑

1. During the past week have you worked for pay?

☐ No ***Please answer the remaining questions.***

☐ Yes ***STOP here. You are done – thank you.***

2. In the past week how much has pain interfered with your ability to work, including housework? *(Please circle one number.)*

0 1 2 3 4 5 6 7 8 9 10

No interference ***Unable to carry on any activities***

3. Please check any areas where you have persistent, bothersome pain:

☐ Low Back ***with pain, numbness, or tingling that travels down your leg***

☐ Low Back *without leg pain*

☐ Head ☐ Neck ☐Shoulder(s)
☐ Arms/Hands ☐Abdomen/Pelvic Area
☐ Hips/Buttocks ☐Legs/Feet
☐ Chest/Rib Cage ☐Upper/Mid Back

☐ No areas with persistent, bothersome pain

4. Since your injury, has your employer offered you light duty, part time work, a flexible schedule, special equipment, or other job modifications if needed to allow you to work?

☐ Yes ☐ No

5. How certain are you that you will be working in six months. *(Please circle one number.)*

0 1 2 3 4 5 6 7 8 9 10

Not at all certain ***Extremely certain***

6. Are you concerned that your work will make your injury or pain worse?

☐Yes ☐ No

Thank you for completing this questionnaire

For Health Care Provider use: **Treatment Plan Notes if 3+ above** (√ on Questions 1-3)

