# 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)

 