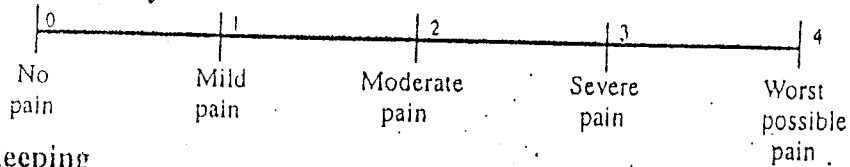


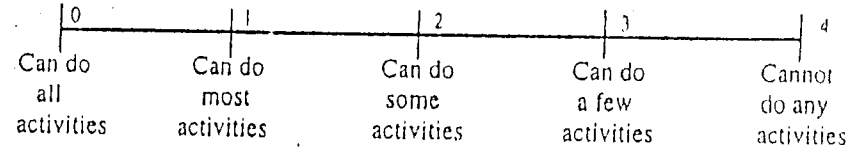
Functional Rating Index

In order to properly assess your condition, we must understand how much your problem(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.

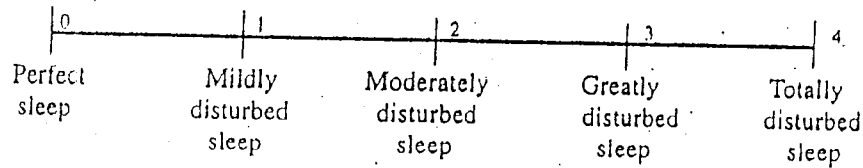
1. Pain Intensity



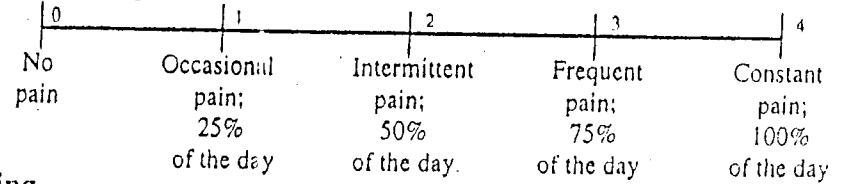
6. Recreation



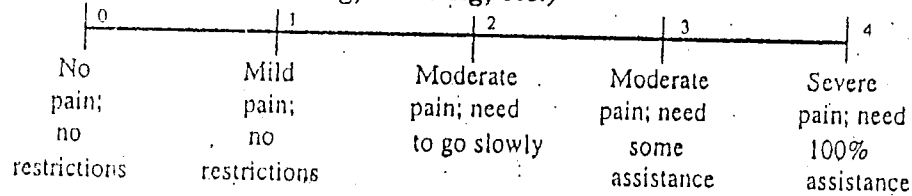
2. Sleeping



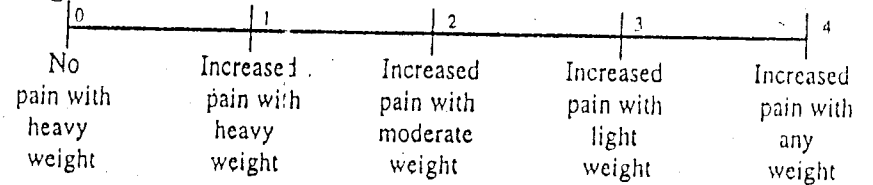
7. Frequency of pain



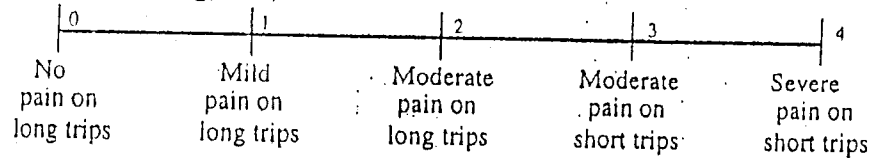
3. Personal Care (washing, dressing, etc.)



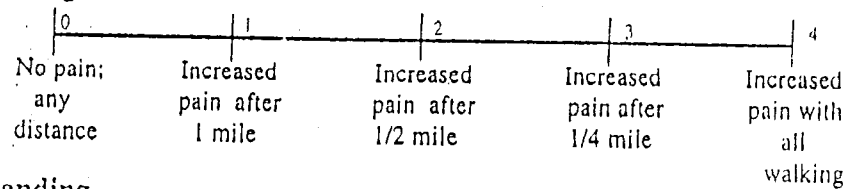
8. Lifting



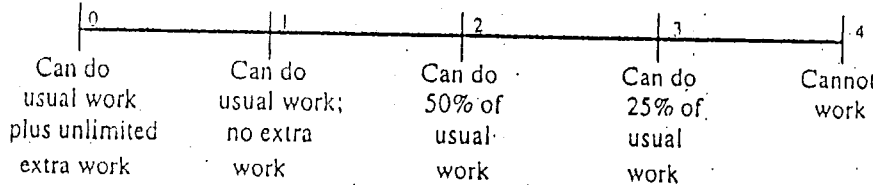
4. Travel (driving, etc.)



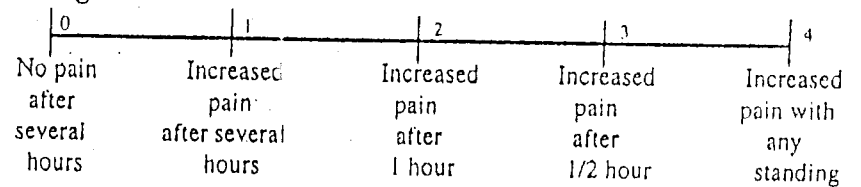
9. Walking



5. Work



10. Standing



Name _____ ID#/SS# _____ Plan ID _____ Total Score _____

PRINTED

Signature _____

Date _____