

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.

### Upper Extremity Functional Scale

We are interested in knowing whether you are having any difficulty with the activities listed below because of your upper limb problem for which you are currently seeking attention. Provide an answer for each activity.

(Circle one number on each line)

Today, do you or would you

have any difficulty with:

Activities

Extreme  
Difficulty  
or Unable  
to Perform  
Activity

Quite a  
Bit of  
Difficulty

Moderate  
Difficulty

A Little  
Bit of  
Difficulty

No  
Difficulty

a. Any of your usual work, household, or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
c. Lifting a bag of groceries to waist level.	0	1	2	3	4
d. Lifting a bag of groceries above your head.	0	1	2	3	4
e. Grooming your hair.	0	1	2	3	4
f. Pushing up on your hands (e.g., from bathtub or chair).	0	1	2	3	4
g. Preparing food (e.g., peeling, cutting).	0	1	2	3	4
h. Driving.	0	1	2	3	4
i. Vacuuming, sweeping, or raking.	0	1	2	3	4
j. Dressing.	0	1	2	3	4
k. Doing up buttons.	0	1	2	3	4
l. Using tools or appliances.	0	1	2	3	4
m. Opening doors.	0	1	2	3	4
n. Cleaning.	0	1	2	3	4
o. Tying or lacing shoes.	0	1	2	3	4
p. Sleeping.	0	1	2	3	4
q. Laundering clothes (e.g., washing, ironing, folding).	0	1	2	3	4
r. Opening a jar.	0	1	2	3	4
s. Throwing a ball.	0	1	2	3	4
t. Carrying a small suitcase with your affected limb).	0	1	2	3	4

COLUMN TOTALS (for physical therapist use)

Score is the sum of all circled items. (range = 0-80)

Score: \_\_\_/80