

Name \_\_\_\_\_ Date \_\_\_\_\_ Pt # \_\_\_\_\_

**UPPER EXTREMITY FUNCTIONAL INDEX**

We are interested in knowing if you are having any difficulty with the activities listed below because of your upper limb (arm) problem for which you are currently seeking treatment. Please provide an answer for each activity.

**Today, do you or would you have any difficulty at all with:** (Circle number on each line)

<b><u>Activities</u></b>	<b>Extremely Difficult</b>	<b>Very Difficult</b>	<b>Moderately Difficult</b>	<b>Somewhat Difficult</b>	<b>Not Difficult</b>
Any of your usual work, housework or school work	0	1	2	3	4
Your usual hobbies, recreational or sporting activities	0	1	2	3	4
Lifting a bag of groceries	0	1	2	3	4
Placing an object up onto, or removing it from an overhead shelf	0	1	2	3	4
Washing or styling your hair	0	1	2	3	4
Pushing yourself up, using your hands (e.g. from a bathtub or chair)	0	1	2	3	4
Preparing food (e.g., peeling, cutting)	0	1	2	3	4
Driving	0	1	2	3	4
Vacuuming, sweeping, or raking	0	1	2	3	4
Dressing yourself, putting on a bra	0	1	2	3	4
Doing buttons	0	1	2	3	4
Using tools or appliances	0	1	2	3	4
Opening doors	0	1	2	3	4
Tying or lacing shoes	0	1	2	3	4
Sleeping	0	1	2	3	4
Laundering clothes (e.g., washing, ironing, folding)	0	1	2	3	4
Opening a jar	0	1	2	3	4
Throwing a ball	0	1	2	3	4
Carrying a small suitcase with your affected arm	0	1	2	3	4
<b>Column Totals:</b>					

**Score:** \_\_\_\_\_/80