

Name: _____ Date: _____

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.

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

	Extreme Difficulty	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
Any of your usual work, household, or school activities	0	1	2	3	4
Your usual hobbies, recreational or sporting activities	0	1	2	3	4
Lifting a bag of groceries above your head	0	1	2	3	4
Lifting a bag of groceries to waist level	0	1	2	3	4
Grooming your hair	0	1	2	3	4
Pushing up on your hands (e.g., from 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	0	1	2	3	4
Doing up buttons	0	1	2	3	4
Using tools or appliances	0	1	2	3	4
Opening doors	0	1	2	3	4
Cleaning	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 limb	0	1	2	3	4

FOR OFFICE USE ONLY

Column totals:	_____	+	_____	+	_____	+	_____	+	_____
	_____ / 80 = _____	-	1 = _____	x100 = _____					Total: _____
	Total		Function		Disability				