Functional Job Demands Form

Patient Use Only

Please complete all of the following information. We pride ourselves in being specialists in the treatment of the injured worker and this information is extremely important in providing you with the best possible care.

Name: _____	Referring Dr.: _____
Phone Number: _____	Date of Injury: _____
DOB: _____	Employer: _____
Diagnosis: _____	Employer Contact: _____
Job Title: _____	Employer #: _____
Work activities that are a problem?	

What percentage of your day is spent performing the following tasks:

Task *Frequency:*	**0%** **Nothing**	**1-33%** **Occasional**	**34-66%** **Frequent**	**67-100%** **Continuous**
Standing				
Sitting				
Lift 20 to 50 lbs.				
Lift 50+ lbs.				
Lift 100+ lbs.				
Carry 20 to 50 lbs.				
Carry 50+ lbs.				
Carry 100+ lbs.				
Push/Pull				
Bend/Squat/Kneel				
Grasping/Pinching				
Below Shoulder Reaching				
Above Shoulder Reaching				
Balance				
Climbing				

THERAPIST USE ONLY

Present Work Status: (circle two) Part Time Full Time Regular Duty Modified/Light Duty

Off of Work? Y N Why: _____ Surgery? Y N

JDA needed?(presently) Y N Ergo consult needed? Y N

FCE needed?(end of treatment) Y N Work Hardening needed? Y N

FPN needed?(during treatment) Y N FDS needed?(at end of treatment) Y N

Therapist Name: _____

Clinic:

Comments: _____

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