

Industrial Physical Therapy, Inc.
Upper Extremity Function Scale

Name: _____ **Signature:** _____ **Date:** _____

Please indicate which of the following things you have difficulty in doing because of your symptoms. Circle the number that indicates how much difficulty you have with each activity.

	No Problem											Major Problem (can't do at all)
Sleeping	0	1	2	3	4	5	6	7	8	9	10	
Writing	0	1	2	3	4	5	6	7	8	9	10	
Opening Jars	0	1	2	3	4	5	6	7	8	9	10	
Picking up small objects with fingers	0	1	2	3	4	5	6	7	8	9	10	
Driving a car more than 30 minutes	0	1	2	3	4	5	6	7	8	9	10	
Opening a door	0	1	2	3	4	5	6	7	8	9	10	
Carrying milk jug from the refrigerator	0	1	2	3	4	5	6	7	8	9	10	
Washing dishes	0	1	2	3	4	5	6	7	8	9	10	