



Upper Extremity Functional Index

Patient Name: _____ Date: _____

This questionnaire has been designed to give your therapist information about how your injury has affected your ability to manage in everyday life. Please mark the (one) box which most closely describes your limitation.

0 = Extreme difficulty or unable to perform activity

1 = Quite a bit of difficulty

2 = Moderate difficulty

3 = A little bit of difficulty

4 = NO difficulty

1.	Any of your usual work, housework or school activities.	0	1	2	3	4
2.	Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
3.	Lifting a bag of groceries to waist level.	0	1	2	3	4
4.	Lifting a bag of groceries above your head.	0	1	2	3	4
5.	Grooming your hair.	0	1	2	3	4
6.	Pushing up on your hands (i.e. from bathtub or chair)	0	1	2	3	4
7.	Preparing food (i.e. peeling, cutting).	0	1	2	3	4
8.	Driving.	0	1	2	3	4
9.	Vacuuming, sweeping or raking.	0	1	2	3	4
10.	Dressing.	0	1	2	3	4
11.	Doing up buttons.	0	1	2	3	4
12.	Using tools or appliances.	0	1	2	3	4
13.	Opening doors.	0	1	2	3	4
14.	Tying or lacing shoes.	0	1	2	3	4
15.	Sleeping.	0	1	2	3	4
16.	Laundering clothes (i.e. Washing, ironing, folding).	0	1	2	3	4
17.	Opening a jar.	0	1	2	3	4
18.	Throwing a ball.	0	1	2	3	4
19.	Carry a small suitcase with your affected limb.	0	1	2	3	4