

The Functional Tolerance Profile

The Functional Tolerance Profile (FTP) also referred to as Client's Estimate of Maximums in the Matheson FCE Software is a very important tool, which when performed correctly serves as a comparison point throughout the FCE in reference to the client's Reliability of Pain and Disability Reports. It is critical that the evaluator learn to perform this interview correctly, as when it is performed incorrectly it is a waste of testing time.

The value of this tool is the comparison of the client's subjective reports to objective findings to examine the consistency of this information throughout the FCE. Furthermore, the Thinking Evaluator will use the conversation around this tool to begin forming a picture of how the client views him/herself in terms of ability/limitations. Additionally, if the client is Reliable in reporting their abilities and limitations, the evaluator can use these functional reports to assist in determining the client's level of ability/limitation. If the client is unreliable, then less weight should be given to this subjective information. Prior to beginning the FTP, familiarize yourself with the client's medical history and diagnosis.

Using the FTP form, or the Matheson FCE Software, interview the client in regard to his/her physical abilities and limitations and find out the reason for any limitations, (e.g., is it due to pain, weakness). The evaluator should be careful not to create too much focus on lengthy descriptions of symptoms for each area of limitation as long descriptions of symptoms do not add value to the FCE.

Procedure

1. Review each Physical Demand asking, for example, "When it comes to lifting, do you have any limitations?" and "How much weight can you lift?" or "How much can you lift on a dependable basis?"
2. If the client is unaware of his or her ability, follow up with a question like, "Do you do your own grocery shopping? What types of items are difficult to lift?"
3. When a limitation is expressed by the client, quantify specifics regarding weights, times, distances, and repetitions; (e.g., Asking if they can lift a $\frac{1}{4}$, $\frac{1}{2}$, or 1 gallon container of milk is helpful for low functioning clients as each $\frac{1}{4}$ gallon is about 2 pounds). For sitting tolerance you can ask questions like – "what is the longest time you have travelled in a car?" "Did you take any breaks during this trip?" "How many?"
4. When a limitation has been presented by the client, the interview should continue with the evaluator asking specifics regarding the reasons a physical ability is difficult (e.g., pain, fatigue). It is also helpful to find out what the client does to manage their pain and functional limitation so you can observe to see if this is consistent with the client's presentation during the evaluation.

5. Next, to be of value as a comparison point throughout the FCE, ask questions that will encourage the client to describe the symptoms they experience while performing the various functional tasks. For example “When I sit for longer than 10 minutes I get a burning pain and tingling and I have to get up and walk around to relieve the symptoms.” The evaluator will then look for consistency in the time spent sitting prior to symptom report or change in function. Noting the client’s reported need to alter function to relieve symptoms and the client’s *actual* function changes will help to further compare the client’s subjective reports with objective findings and observations.
6. A well-documented description, including information as presented in the following example, will allow the evaluator to compare subjective and objective information strengthening the RPDR Profile.

“I can only sit for 15 minutes at a time because my left leg becomes numb and my low back falls asleep. When I stand, the pain shoots down my leg to my ankle and I have to take a few minutes to stretch. After I do this I can stand and walk without difficulty. I can return to sitting after about 10 minutes of being on my feet.” This information can be compared to later performance in the clinic. (Note that if the client is currently in a seated position his limitation should manifest if he remains seated for more than 15 minutes).

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Functional Tolerance Profile

Name: _____ Date: _____

Position	Client's Estimate	Limited by (Sx, be specific)
Sitting:		
Standing:		
Walking:		
Climbing:		
Balance:		
Stooping:		
Kneeling:		
Crouching:		
Reaching:		
Lifting:		
Carrying:		
Handling:		
Fingering:		
Feeling:		
Driving:		

1. The Client

Reported Functional Tolerances

	Client's Estimate of Current Ability	Limited By
Position		
Static Standing		
Dynamic Standing		
Walking		
Sitting		
Weight/Force		
Lifting 1 Floor to Knuckle		
Lifting 2 Knuckle to Shoulder		
Lifting 3 Shoulder to Overhead		
Carrying		
*Pushing		
*Pulling		
Agility		
Climbing		
Balancing		
Stooping		
Crouching		
Crawling		
Twisting/Spinal Rotation		
Low-Level Work		
Prolonged Neck Positioning		

Dexterity		
Reaching Forward		
Handling		
Fingering		
Above-Shoulder Work		
Pinching		
Writing		

Repetitive Movement Tests

Test	Time of Day	Pain Rating	Comments
Overhead Reaching x 10			
Overhead Reaching x 10			
Overhead Reaching x 10			
Forward Reaching x 10			
Forward Reaching x 10			
Forward Reaching x 10			
Stooping x 10			
Stooping x 10			
Stooping x 10			
Sit/Stand Test x 10			
Sit/Stand Test x 10			
Sit/Stand Test x 10			
Crouching x 5			
Crouching x 5			
Crouching x 5			
50' Walk Test			
50' Walk Test			
50' Walk Test			

COMMENTS:

Willingness to move _____

Range of motion _____

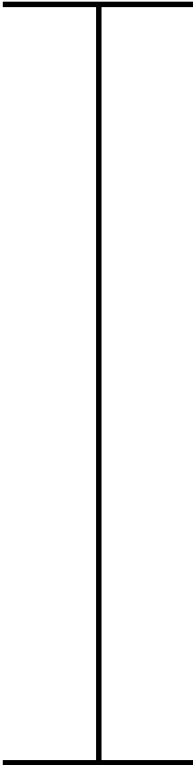
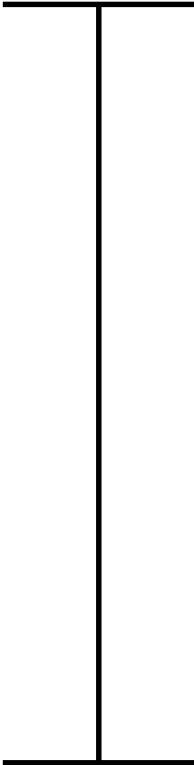
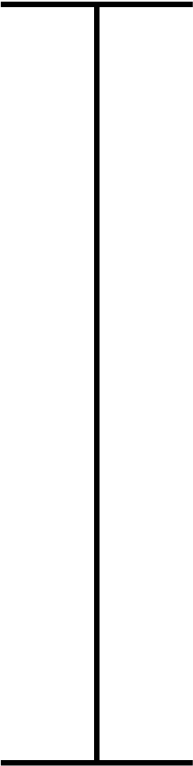
Quality, rhythm, speed of movement _____

Symmetry of movement _____

Consistency of movement _____

The Visual Analogue Pain Scale
Instructions

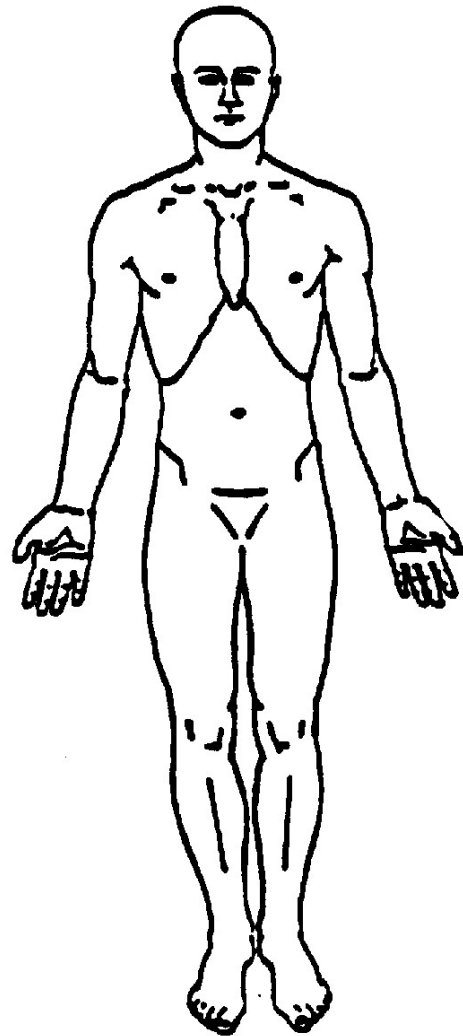
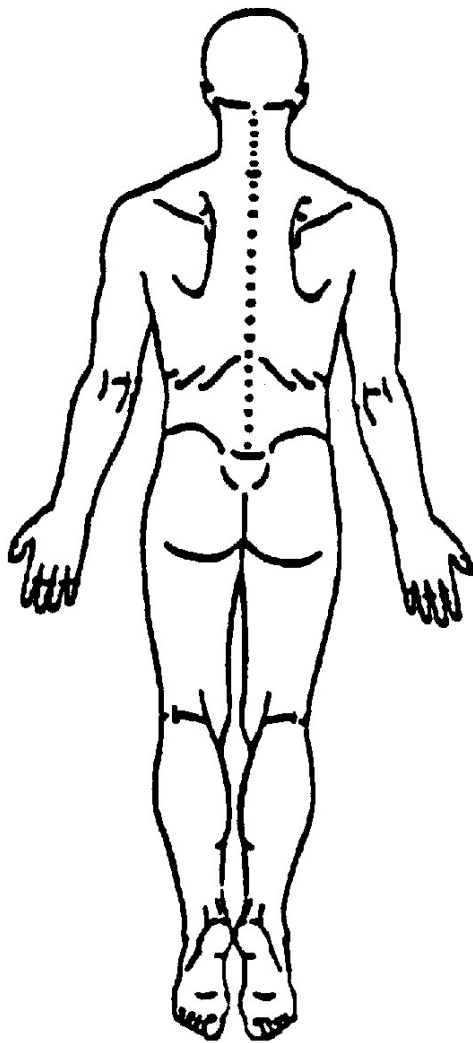
Place a mark (-) across each of the three lines to indicate your pain today, your worst pain over the past 30 days, and your pain on the best day over the last 30 day. Indicate how bad your pain is between the extremes of “No Pain At All” on the bottom of the lines and “Pain As Bad As It Could Be” on the top of the lines.

<u>PAIN TODAY</u>	<u>PAIN OVER THE PAST 30 DAYS</u>	
	<u>WORST DAY</u>	<u>BEST DAY</u>
Pain As Bad <u>As It Could Be</u>	Pain As Bad <u>As it Could Be</u>	Pain As Bad <u>As It Could Be</u>
		
<u>No Pain At All</u>	<u>No Pain At All</u>	<u>No Pain At All</u>

The Ransford Pain Drawing
Instructions to the Client

Indicate where your pain is located and what type of pain you feel at the present time.
Use the symbols below to describe your pain. Do not indicate areas of pain which are not
related to your present injury or condition.

Key	/// Stabbing	XXX Burning	000 Pins and Needles	=== Numbness
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The Oswestry Low Back Disability Questionnaire

How long have you had back pain? _____ Years _____ Months _____ Weeks

How long have you had leg pain? _____ Years _____ Months _____ Weeks

Please read:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the *one box* which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just *mark the box which most closely describes your problem*.

Section 1 – Pain Intensity		Section 3 – Standing	
<input type="checkbox"/>	I can tolerate the Pain I have without having to use pain killers.	<input type="checkbox"/>	I can stand as long as I want without extra pain.
<input type="checkbox"/>	The pain is bad but I manage with taking pain killers.	<input type="checkbox"/>	I can stand as long as I want but it gives me extra pain.
<input type="checkbox"/>	Pain killers give complete relief from pain.	<input type="checkbox"/>	Pain prevents me from standing for more than 1 hour.
<input type="checkbox"/>	Pain killers give moderate relief from pain.	<input type="checkbox"/>	Pain prevents me from standing for more than 30 minutes.
<input type="checkbox"/>	Pain killers give very little relief from pain.	<input type="checkbox"/>	Pain prevents me from standing for more than 10 minutes.
<input type="checkbox"/>	Pain killers have no effect on the pain and I do not use them.	<input type="checkbox"/>	Pain prevents me from standing at all.

Section 2 – Personal Care (Washing, Dressing, etc.)		Section 4 – Sleeping	
<input type="checkbox"/>	I can look after myself normally without causing extra pain.	<input type="checkbox"/>	Pain does not prevent me from sleeping well.
<input type="checkbox"/>	I can look after myself normally but it causes extra pain.	<input type="checkbox"/>	I can sleep well only by using tablets.
<input type="checkbox"/>	It is painful to look after myself and I am slow and careful.	<input type="checkbox"/>	Even when I take tablets I have less than six hours sleep.
<input type="checkbox"/>	I need some help but manage most of my personal care.	<input type="checkbox"/>	Even when I take tablets I have less than five hours sleep.
<input type="checkbox"/>	I need help every day in most aspects of self care.	<input type="checkbox"/>	Even when I take tablets I have less than two hours sleep.
<input type="checkbox"/>	I do not get dressed, was with difficulty and stay in bed.	<input type="checkbox"/>	Pain prevents me from sleeping at all.

Section 5 - Lifting		Section 8 – Sex Life	
<input type="checkbox"/>	I can lift heavy weights without extra pain.	<input type="checkbox"/>	My sex life is normal and causes no extra pain.
<input type="checkbox"/>	I can lift heavy weights but it gives extra pain.	<input type="checkbox"/>	My sex life is normal but causes some pain.
<input type="checkbox"/>	Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned.	<input type="checkbox"/>	My sex life is normal but it is very painful.
<input type="checkbox"/>	Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.	<input type="checkbox"/>	My sex life is severely restricted by pain.
<input type="checkbox"/>	I can lift only very light weights.	<input type="checkbox"/>	My sex life is nearly absent because of pain.
<input type="checkbox"/>	I cannot lift or carry anything at all.	<input type="checkbox"/>	Pain prevents any sex life at all.

Section 6 - Walking		Section 9 – Social Life	
<input type="checkbox"/>	Pain does not prevent me from walking any distance.	<input type="checkbox"/>	My social life is normal and gives me no extra pain.
<input type="checkbox"/>	Pain prevents me from walking more than 1 mile.	<input type="checkbox"/>	My social life is normal but increases the degree of pain.
<input type="checkbox"/>	Pain prevents me walking more than ½ mile.	<input type="checkbox"/>	Pain has no significant effect on my social life apart from limiting my more energetic interests, eg dancing, etc.
<input type="checkbox"/>	Pain prevents me walking more than ¼ mile.	<input type="checkbox"/>	Pain has restricted my social life and I do not go out as often.
<input type="checkbox"/>	I can only walk using a stick or crutches.	<input type="checkbox"/>	Pain has restricted my social life to my home.
<input type="checkbox"/>	I am in bed most of the time and have to crawl to the toilet.	<input type="checkbox"/>	I have no social life because of pain.

Section 7 - Sitting		Section 10 – Traveling	
<input type="checkbox"/>	I can sit in any chair as long as I like.	<input type="checkbox"/>	I can travel anywhere without extra pain.
<input type="checkbox"/>	I can only sit in my favorite chair as long as I like.	<input type="checkbox"/>	I can travel anywhere but it gives me extra pain.
<input type="checkbox"/>	Pain prevents me sitting more than 1 hour.	<input type="checkbox"/>	Pain is bad but I can manage journeys over two hours.
<input type="checkbox"/>	Pain prevents me sitting more than ½ hour.	<input type="checkbox"/>	Pain restricts me to journeys of less than 1 hour.
<input type="checkbox"/>	Pain prevents me sitting more than ¼ hour.	<input type="checkbox"/>	Pain restricts me to short necessary journeys under 30 mins.
<input type="checkbox"/>	Pain prevents me from sitting at all.	<input type="checkbox"/>	Pain prevents me from travelling except to the doctor or hospital.

Comments: _____

The Neck Disability Index

This questionnaire has been designed to give your therapist information as to how your neck pain has affected you in your everyday life activities. Please answer each section, marking only ONE box which best describes your status today.

Section 1 — Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment.

Section 2— Personal Care (Washing, dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it causes me extra pain.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

Section 3—Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very lightweights.
- I cannot lift or carry anything at all.

Section 4— Reading

- I can read as much as I want to with no pain in my neck.
- I can read as much as I want to with slight pain in my neck.
- I can read as much as I want with moderate pain in my neck.
- I can't read as much as I want because of moderate pain in my neck.
- I can hardly read at all because of severe pain in my neck.
- I cannot read at all.

Section 5 — Headache

- I have no headache at all.
- I have slight headaches which come infrequently.
- I have moderate headaches which come infrequently.
- I have moderate headaches which come frequently.
- I have severe headaches which come frequently.
- I have headaches almost all the time.

Section 6 — Concentration

- I can concentrate fully when I want to with no difficulty.
- I can concentrate fully when I want to with slight difficulty.
- I have a fair degree of difficulty in concentrating when I want to.
- I have a lot of difficulty in concentrating when I want to.
- I have a great deal of difficulty in concentrating when I want to.
- I cannot concentrate at all.

Section 7—Work

- I can do as much as I want to.
- I can only do my usual work but no more.
- I can do most of my usual work, but no more.
- I cannot do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.

Section 8— Driving

- I can drive my car without any neck pain.
- I can drive my car as long as I want with slight pain in my neck.
- I can drive my car as long as I want with moderate pain in my neck.
- I can't drive my car as long as I want because of moderate pain in my neck.
- I can hardly drive at all because of severe pain in my neck.
- I can't drive my car at all.

Section 9—Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed (less than 1 hour sleep loss).
- My sleep is mildly disturbed (1-2 hour sleep loss).
- My sleep is moderately disturbed (2-3 hours sleep loss).
- My sleep is greatly disturbed (3-5 hours sleep loss).
- My sleep is completely disturbed (5-7 hours sleep loss),,

Section 10— Recreation

- I am able to engage in all my recreational activities with no neck pain at all.
- I am able to engage in all my recreational activities with some pain in my neck.
- I am able to engage in most but not all of my usual recreational activities because of pain in my neck.
- I am able to engage in a few of my usual recreational activities because of pain in my neck.
- I can hardly do any recreational activities because of pain in my neck.
- I can't do any recreational activities at all.

Comments: _____

The McGill Pain Questionnaire
Instructions to the Client

There are many words that describe pain. Some of these are grouped below. Look at each group of words and circle any word which describes the pain you are experiencing right now. Continue until you have finished all 20 word groups. You should choose only one word from every word group but you do not have to choose a word from every word group. If none of the words in a particular word group describes your pain, go to the next word group.

1.
Flickering
Quivering
Pulsing
Throbbing
Beating
Pounding

2.
Jumping
Flashing
Shooting

3.
Pricking
Boring
Drilling
Stabbing
Lancinating

4.
Sharp
Cutting
Lacerating

5.
Pinching
Pressing
Gnawing
Cramping
Crushing

6.
Tugging
Pulling
Wrenching

7.
Hot
Burning
Scalding
Searing

8.
Tingling
Itchy
Smarting
Stinging

9.
Dull
Sore
Hurting
Aching
Heavy

10.
Tender
Taut
Rasping
Splitting

11.
Tiring
Exhausting

12.
Sickening
Suffocating

13.
Fearful
Frightful
Terrifying

14.
Punishing
Grueling
Cruel
Vicious
Killing

15.
Wretched
Blinding

16.
Annoying
Troublesome
Miserable
Intense
Unbearable

17.
Spreading
Radiating
Penetrating
Piercing

18.
Tight
Numb
Drawing
Squeezing
Tearing

19.
Cool
Cold
Freezing

20.
Nagging
Nauseating
Agonizing
Dreadful
Torturing

The Dallas Pain Questionnaire Instructions

Mark an "X" along the line that expresses your thoughts from 0% to 100% in each section. Read each statement carefully. There are words to help you with each statement. If you need help, please ask.

Section I: Pain Intensity

To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None
0% (_____ : _____ : _____ : _____ : _____ : _____) 100%

Some

All the time

Section II: Personal Care

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc.)?

None
(no pain)
0% (_____ : _____ : _____ : _____ : _____ : _____) 100%

Some

I cannot get
out of bed

Section III: Lifting

How much limitation do you notice in lifting?

None
(I can lift as I did)
0% (_____ : _____ : _____ : _____ : _____ : _____) 100%

Some

I cannot lift
anything

Section IV: Walking

Compared to how far you could walk before your injury or back trouble, how much does pain restrict your walking now?

I can walk
the same
0% (_____ : _____ : _____ : _____ : _____ : _____) 100%

Almost the
same

Very Little

I cannot
walk

Section V: Sitting

Back pain limits my sitting in a chair to:

None, pain

I cannot sit

Section XVI: Punishing Response

How much do you think others express irritation, frustration or anger toward you because of your pain?

None _____ Some _____ All the Time _____
0% (_____ : _____ : _____ : _____ : _____ : _____ : _____) 100%

(_____ X 5 = _____ % Social Interest Interference

Waddell's Non-Organic Signs

Data Collection Form

SIGNS	ORGANIC	NON-ORGANIC	+ / -
1. Superficial tenderness	Musculoskeletal boundaries	Non-anatomic	
2. Deep tenderness	Musculoskeletal boundaries	Non-anatomic	
3. Axial loading	Neck pain	Low Back Pain	
4. Simulated Rotation	Nerve root pain	Low Back Pain	
5. Straight leg raise	Limited supine-no improvement with distraction	>40 degree improvement with distraction	
6. Motor weakness	Myotomal	Regional, jerky, giving way.	
7. Sensory Loss	Dermatomal	Regional, jerky, giving way.	

Placebo Tests

Data Collection Form

PLACEBO TESTS	POSITIVE/NEGATIVE
Ankle Dorsiflexion Test	
Wrist Flexion/Extension Test	
Patellar Shift Test	
Isolated Finger Distraction Test	
Olecranon Shift Test	

Chronic Pain Assessment/Questionnaires

Summary Sheet

Questionnaire/Assessment Interpretation	Score		
Visual Analogue Scale	_____	cm	_____
Functional Pain Scale	_____	/10	_____
Ransford Drawing	_____	points	_____
McGill Pain Questionnaire	_____	points	_____
Inappropriate Symptom Questionnaire	_____	/7	_____
Oswestry Low Back Disability	_____	%	_____
Oswestry Neck Disability	_____	%	_____
Dallas Pain Questionnaire - Factor I	_____	%	_____
- Factor II	_____	%	_____
- Factor III	_____	%	_____
- Factor IV	_____	%	_____
Questionnaire			
_____	_____		_____
_____	_____		_____