

UPPER Extremity Functional Index (UEFI)

Name _____ **Today's Date** _____

Date of Birth _____

We are interested in knowing whether you are having any difficulty at all with the activities listed below **because of your upper limb** problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Rate your level of pain with activity: No Pain 0 1 2 3 4 5 6 7 8 9 10 Very Severe Pain

How satisfied are you with your level of care and service provided?	Very Satisfied	Satisfied	Unsatisfied	Very Unsatisfied
Please rate your progress with function activities from start of therapy to this point in time	Excellent	Good	Fair	Poor
At this point in your treatment, have your therapy goals been met?	Completely Met	Mostly Met	Partially Met	Not Met

Today, do you or would you have any difficulty at all with: Activities	Extreme difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
	0	1	2	3	4
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 (eg from bathtub or chair)	0	1	2	3	4
7. Preparing food (eg 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. Cleaning	0	1	2	3	4
15. Tying or lacing shoes	0	1	2	3	4
16. Sleeping	0	1	2	3	4
17. Laundering clothes (eg washing, ironing, folding)	0	1	2	3	4
18. Opening a jar	0	1	2	3	4
19. Throwing a ball.	0	1	2	3	4
20. Carrying a small suitcase with your affected limb	0	1	2	3	4
Column Totals:	=	=	=	=	=
Total out of 80	/80				