NORTHERN
Physical Therapy

Essential Job Function Questionnaire

Patient Name: ____ **Date:** ______________

Employer: ________________________________ **Job Title:** ________________________

The purpose of this questionnaire is to help identify the specific physical demands of your job. Please be as specific as possible and circle or write in appropriate answer.

Lifting: Do you need to lift items or products at your job? ___ Yes ___ No
What is the heaviest amount of weight you need to lift by yourself? ____________
Do you need to lift from the ground? ___ Yes ___ No
Do you need to lift overhead? ___ Yes ___ No
How frequently do you need to lift this weight during your average work day?
___ 1-5x per hour ___ 5-10x per hour ___ >10x per hour

Carrying: Do you need to carry objects/items at work? ___ Yes ___ No
What is the heaviest amount of weight you need to carry by yourself? ____________
How far do you need to carry this weight? ____________
Do you carry with one hands or two hands? ___ One hand ___ Two hands
How often do you need to carry this weight during your average work day?
___ 1-5x per hour ___ 5-10x per hour ___ >10x per hour

Push/Pull: Do you need to push/pull objects/items at work? ___ Yes ___ No
What is the heaviest amount of weight you need to push/pull by yourself? ____________
How far do you need to push/pull? ____________
How often do you need to push/pull this weight during your average work day?
___ 1-5x per hour ___ 5-10x per hour ___ >10x per hour

Climbing: Do you need to climb stairs? ___ Yes ___ No Do you need to climb ladders? ___ Yes ___ No
How many steps/rungs?___________
How many times per day? ___ 1-5x per hour ___ 5-10x per hour ___ >10x per hour

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Sitting: Does your job require you to sit? ___ Yes ___ No If yes, how long must you sit at one time? ____________

Standing: Does your job require you to stand? ___ Yes ___ No If yes, how long must you stand at one time? ____________

Walking: On average, how far do you think you walk during your work day? ____________

Gripping/Pinching: Do you need to grip or pinch tools or objects? ___ Yes ___ No
Are you right or left handed? ___ Right ___ Left Are both hands required for your job? ___ Yes ___ No
Do you need to use your arms and hands in a repetitive manner? ___ Yes ___ No

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Postures: Does your job require you to do the following, check all that apply
___ squat ___ reach overhead ___ crouch in confined spaces ___ bend at the waist

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Personal Protective Equipment (PPE) / Tools: Please list any PPE or tools you must wear or use at your job:

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Other: List any other activities that would be difficult or impossible to perform at work with your current injury:

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I acknowledge that my answers most accurately depict the essential functions of my job. I have answered the questions based on my knowledge and recollection and the answers may be used to establish my physical or occupational therapy goals and plan.

Patient Signature: ____ Date:________________