Name:_____
Date:_____

Self-Report Functional Measures

You may be having some difficulty with some of the activities listed below because of the current problem for which you are seeking treatment. Rate the amount of difficulty below by circling one number for each item. Add any additional activities you're finding difficult and rate the as well.

Activity	Extreme Difficulty or Unable to do at all	Quite a bit of difficulty	Moderate difficulty	A Little Bit of Difficulty	No Difficulty
Biting hard food e.g. raw carrot with your front teeth	0	1	2	3	4
Biting into medium texture food e.g. bread with your front teeth	0	1	2	3	4
biting into large item e.g. hamburger/ apple with your front teeth	0	1	2	3	4
chewing hard food e.g. nuts with your back teeth	0	1	2	3	4
chewing medium food e.g. bread with your back teeth	0	1	2	3	4
yawning	0	1	2	3	4
laughing	0	1	2	3	4
talking	0	1	2	3	4
	0	1	2	3	4
	0	1	2	3	4
COLUMN TOTALS					

SCORE:_____/_____