

- 1 Date of Birth** \_\_\_\_\_  
mm / dd / yyyy
- 2 Sex** 1) \_\_\_ Male  
2) \_\_\_ Female
- 3 Race** 1) \_\_\_ Aleut/Eskimo  
2) \_\_\_ American Indian  
3) \_\_\_ Asian/Pacific Islander  
4) \_\_\_ Black  
5) \_\_\_ White  
6) \_\_\_ Other
- 4 Ethnicity** 1) \_\_\_ Hispanic or Latino  
2) \_\_\_ Not Hispanic or Latino
- 5 Insurance** (Please check all that apply)  
1) \_\_\_ Workers' compensation  
2) \_\_\_ Self-pay  
3) \_\_\_ HMO/PPO/private insurance  
4) \_\_\_ Medicare  
5) \_\_\_ Medicaid  
6) \_\_\_ Auto  
7) \_\_\_ Other
- 6 Education** (Please check one)  
1) \_\_\_ Less than high school  
2) \_\_\_ Some high school  
3) \_\_\_ High school graduate  
4) \_\_\_ Attended or graduated from technical school  
5) \_\_\_ Attended college, did not graduate  
6) \_\_\_ College graduate  
7) \_\_\_ Completed graduate school/advanced degree
- 7 Please check the combined annual income of everyone in your house:**  
1) \_\_\_ Less than \$10,000  
2) \_\_\_ \$10,000–\$14,999  
3) \_\_\_ \$15,000–\$24,999  
4) \_\_\_ \$25,000–\$34,999  
5) \_\_\_ \$35,000–\$49,999  
6) \_\_\_ \$50,000–\$74,999  
7) \_\_\_ \$75,000–\$99,999  
8) \_\_\_ \$100,000–\$149,999  
9) \_\_\_ \$150,000 or more
- 8. Employment/Work** (Check all that apply)  
1) \_\_\_ Working full-time outside of home  
2) \_\_\_ Working part-time outside of home  
3) \_\_\_ Working full-time from home  
4) \_\_\_ Working part-time from home  
5) \_\_\_ Working with modification in job because of current illness/injury  
6) \_\_\_ Not working because of current illness/injury  
7) \_\_\_ Homemaker  
8) \_\_\_ Student  
9) \_\_\_ Retired  
10) \_\_\_ Unemployed  
Occupation: \_\_\_\_\_
- 9. Do you use a:** (Check all that apply)  
1) \_\_\_ Cane?  
2) \_\_\_ Walker, rolling walker, or rollator?  
3) \_\_\_ Manual wheelchair?  
4) \_\_\_ Motorized wheelchair?  
5) \_\_\_ Other: \_\_\_\_\_
- 10. With whom do you live?** (Check all that apply)  
1) \_\_\_ Alone  
2) \_\_\_ Spouse/significant other  
3) \_\_\_ Child/children  
4) \_\_\_ Other relative(s)  
5) \_\_\_ Group setting  
6) \_\_\_ Personal care attendant  
7) \_\_\_ Other: \_\_\_\_\_
- 11. Where do you live?**  
1) \_\_\_ Private home  
2) \_\_\_ Private apartment  
3) \_\_\_ Rented room  
4) \_\_\_ Board and care/assisted living/group home  
5) \_\_\_ Homeless (with or without shelter)  
6) \_\_\_ Long-term care facility (nursing home)  
7) \_\_\_ Hospice  
8) \_\_\_ Other

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther.* 2005;85:515–530.

# OPTIMAL INSTRUMENT

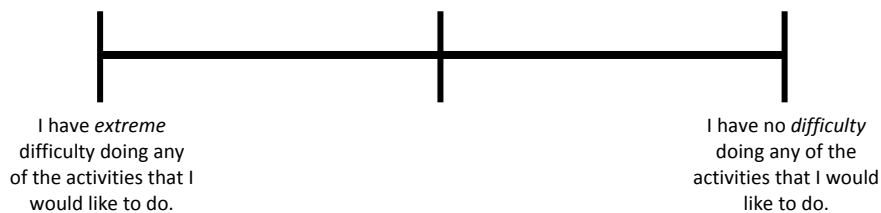
Patient Name: \_\_\_\_\_

## Difficulty–Baseline

Patient ID: \_\_\_\_\_

Instructions: Please circle the level of <b>DIFFICULTY</b> you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1. \_\_\_\_ 2. \_\_\_\_ 3. \_\_\_\_

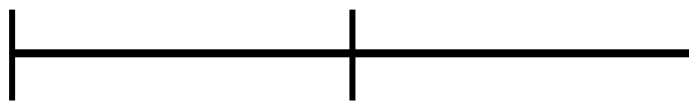
Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

### Confidence–Baseline

Instructions: Please circle the level of <b>CONFIDENCE</b> you have for doing each activity today.	Fully confident in my ability to perform	Very confident	Moderate confidence	Some confidence	Not confident in my ability to perform	Not applicable
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all the activities you like to do, please mark an “X” at the point on the line that best describes your overall level of confidence in performing these activities today:



I have *no confidence* that I can do activities that I would want to do.

I have *complete confidence* that I can do activities that I would want to do.

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