



OPTIMAL INSTRUMENT Demographic Information

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: _____

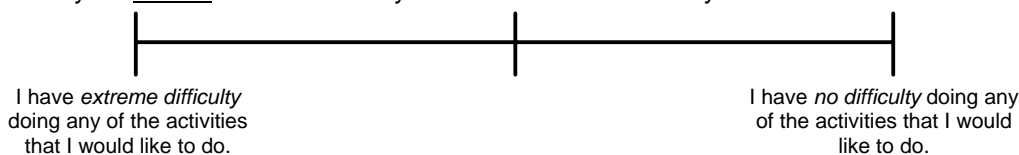
11. Where do you live?
1) ___ Private home
2) ___ Private apartment
3) ___ Rented room
4) ___ Board and care/assisted living/group home
5) ___ Homeless (with or without shelter)
6) ___ Long-term care facility (nursing home)
7) ___ Hospice
8) ___ Other

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.

Difficulty–Baseline

Instructions: Please circle the level of difficulty 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. ____

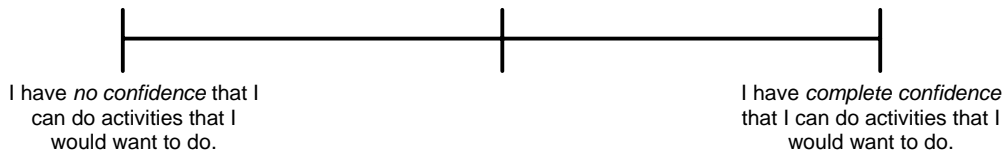
NAME : _____

DATE: _____

Confidence–Baseline

Instructions: Please circle the level of confidence 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:



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