

Patient Specific Functional Scale

Summary

Description: The Patient Specific Functional Scale (PSFS) is a patient-specific outcome measure which investigates functional status (Stratford et al 1995). Patients are asked to nominate up to five activities with which they have difficulty due to their condition and then rate the functional limitation associated with these activities. The PSFS is intended to complement the findings of generic or condition-specific measures.

Instructions to client and scoring: At initial assessment, clients are asked 'Today, are there any activities that you are unable to do or having difficulty with because of your [nominated] problem?' Clients then rate their functional limitation with each nominated activity on a 0 to 10 scale, where 0 = unable to perform activity and 10 = able to perform activity at same level as before injury or problem. At follow-up assessments clients are asked again to rate each of their previously nominated activities on the same scale. There is

no total score calculated and the PSFS is not designed to compare clients, rather individual items are followed over time. The PSFS takes only 5–10 minutes to complete and score, requires no special training to administer, and is available from the original paper (Stratford et al 1995) and at www.tac.vic.gov.au.

Reliability, validity and sensitivity to change: The PSFS has been shown to be valid and responsive to change in musculoskeletal conditions such as neck pain, cervical radiculopathy, knee pain, and low back pain (Chatman et al 1997, Cleland 2006, Pengel 2004, Westaway 1998). When compared to other instruments, the PSFS has been shown to be more responsive than the Neck Disability Index (Cleland 2006), the Pain Rating Index, and the Roland Morris questionnaire (Pengel 2004).

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Commentary

Improving function in activities that are meaningful to our patients is an important role for physiotherapists. The Patient Specific Functional Score (PSFS) is an outcome measure which assists in identifying activities impaired by illness or injury and provides a measure of clinical outcome that has been shown to be valid and sensitive for many musculoskeletal conditions.

The PSFS is generally included as part of the subjective examination and it is quick to apply in both the initial and, more importantly for busy clinicians, the subsequent assessment. In pain-focused patients the PSFS is useful to redirect questioning towards function and ability rather than pain and disability. Clinically the PSFS is simple to administer and does not require the subtle nuances to rank, unlike disabilities questionnaires. This is especially important to patients where English is a second language.

It is advantageous to assist the patient to select activities they are likely to perform prior to the subsequent assessment so that a comparison may be drawn. If treatment is being directed towards a work-related injury it is important that occupational activities are included to align with the broader goal of return to work. It is also of benefit to nominate a period of time when including static activities, such as 30 minutes of sitting, and record this for a specific chair so that accurate comparison may be performed in the future.

Clinicians should be aware that while the PSFS is able to be applied to many areas of the body it has not yet been shown to be valid for all musculoskeletal conditions. The minimal detectable change (90% CI) for an average score is 2 points, and 3 points for a single activity score (Stratford 1995).

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References

- Chatman A (1997) *Phys Ther* 77:820–829.
 Cleland J (2006) *Spine* 31: 598–602.
 Pengel L (2004) *Spine* 29: 879–883.
 Stratford P (1995) *Physiother Can* 47: 258–263.
 Westaway M (1998) *JOSPT* 27: 331–338.