LEFS FORM

# LOWER EXTREMITY FUNCTIONAL SCALE

Thank you for completing this patient-reported outcome questionnaire. Your responses help your provider determine the best treatment options and track your recovery progress over time. Please answer each of the questions included on this form.

**NAME:** _____ **DATE OF BIRTH:** (MM/DD/YYYY) _____

**DID YOU HAVE SURGERY FOR THIS ISSUE PRIOR TO RECEIVING THERAPY?** ☐ YES ☐ NO

**PAIN SCORE: OVER THE PAST 24 HOURS, HOW BAD HAS YOUR PAIN BEEN?**
CIRCLE THE NUMBER THAT BEST REPRESENTS YOUR PAIN.

**NO PAIN** 0 1 2 3 4 5 6 7 8 9 10 **WORST IMAGINABLE PAIN**

**TODAY, DO YOU OR WOULD YOU HAVE ANY DIFFICULTY AT ALL WITH:**
FOR EACH ROW, MARK THE ONE BOX WHICH MOST CLOSELY DESCRIBES YOUR CURRENT CONDITION.

| | EXTREME DIFFICULTY OR UNABLE TO PERFORM | QUITE A BIT OF DIFFICULTY | MODERATE DIFFICULTY | A LIT BIT OF DIFFICULTY | NO DIFFICULTY |
|---|---|---|---|---|---|
| 1. ANY OF YOUR USUAL WORK, HOUSEWORK, OR SCHOOL ACTIVITIES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. YOUR USUAL HOBBIES, RECREATIONAL OR SPORTING ACTIVITIES | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. GETTING INTO OR OUT OF THE BATH | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4. WALKING BETWEEN ROOMS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5. PUTTING ON YOUR SHOES OR SOCKS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6. SQUATTING | ☐ | ☐ | ☐ | ☐ | ☐ |





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|---|---|---|---|---|---|
| 7. LIFTING AN OBJECT, LIKE A BAG OF GROCERIES FROM THE FLOOR | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8. PERFORMING LIGHT ACTIVITIES AROUND YOUR HOME | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9. PERFORMING HEAVY ACTIVITIES AROUND YOUR HOME | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10. GETTING INTO OR OUT OF A CAR | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11. WALKING 2 BLOCKS | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12. WALKING A MILE | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13. GOING UP OR DOWN 10 STAIRS (ABOUT 1 FLIGHT OF STAIRS) | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14. STANDING FOR 1 HOUR | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15. SITTING FOR 1 HOUR | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16. RUNNING ON EVEN GROUND | ☐ | ☐ | ☐ | ☐ | ☐ |
| 17. RUNNING ON UNEVEN GROUND | ☐ | ☐ | ☐ | ☐ | ☐ |
| 18. MAKING SHARP TURNS WHILE RUNNING FAST | ☐ | ☐ | ☐ | ☐ | ☐ |
| 19. HOPPING | ☐ | ☐ | ☐ | ☐ | ☐ |
| 20. ROLLING OVER IN BED | ☐ | ☐ | ☐ | ☐ | ☐ |





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