

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 PHYSICAL THERAPY?

☐ YES – DATE: (MM/DD/YYYY) _____

☐ NO

DID YOU HAVE SURGERY FOR THIS ISSUE DURING THE COURSE OF RECEIVING PHYSICAL THERAPY?

☐ YES – DATE: (MM/DD/YYYY) _____

☐ 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. YOUR USUAL HOBBIES, RECREATIONAL OR SPORTING ACTIVITIES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. GETTING INTO OR OUT OF THE BATH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. WALKING BETWEEN ROOMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. PUTTING ON YOUR SHOES OR SOCKS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. SQUATTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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