



# THE LOWER EXTREMITY FUNCTIONAL SCALE

NAME \_\_\_\_\_

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

Did you have surgery for this issue prior to receiving therapy?

[circle one]

YES NO

Over the past 24 hours, how bad has your pain been?

[input a number between 1 and 10]

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

| Activities            |  | Extreme Difficulty/<br>Unable to Perform Activity | Quite a Bit of Difficulty | Moderate Difficulty | A Little Bit of Difficulty | No Difficulty |
|-----------------------|--|---|---------------------------|---------------------|----------------------------|---------------|
| 1                     | Any of your usual work, housework, or school activities.   | 0   | 1                         | 2                   | 3                          | 4             |
| 2                     | Your usual hobbies, re creational or sporting activities.  | 0   | 1                         | 2                   | 3                          | 4             |
| 3                     | Getting into or out of the bath.                           | 0   | 1                         | 2                   | 3                          | 4             |
| 4                     | Walking between rooms.                                     | 0   | 1                         | 2                   | 3                          | 4             |
| 5                     | Putting on your shoes or socks.                            | 0   | 1                         | 2                   | 3                          | 4             |
| 6                     | Squatting.   | 0   | 1                         | 2                   | 3                          | 4             |
| 7                     | Lifting an object, like a bag of groceries from the floor. | 0   | 1                         | 2                   | 3                          | 4             |
| 8                     | Performing light activities around your home.              | 0   | 1                         | 2                   | 3                          | 4             |
| 9                     | Performing heavy activities around your home.              | 0   | 1                         | 2                   | 3                          | 4             |
| 10                    | Getting into or out of a car.                              | 0   | 1                         | 2                   | 3                          | 4             |
| 11                    | Walking 2 blocks.  | 0   | 1                         | 2                   | 3                          | 4             |
| 12                    | Walking a mile.  | 0   | 1                         | 2                   | 3                          | 4             |
| 13                    | Going up or down 10 stairs (about 1 flight of stairs).     | 0   | 1                         | 2                   | 3                          | 4             |
| 14                    | Standing for 1 hour.                                       | 0   | 1                         | 2                   | 3                          | 4             |
| 15                    | Sitting for 1 hour.  | 0   | 1                         | 2                   | 3                          | 4             |
| 16                    | Running on even ground.                                    | 0   | 1                         | 2                   | 3                          | 4             |
| 17                    | Running on uneven ground.                                  | 0   | 1                         | 2                   | 3                          | 4             |
| 18                    | Making sharp turns while running fast.                     | 0   | 1                         | 2                   | 3                          | 4             |
| 19                    | Hopping.   | 0   | 1                         | 2                   | 3                          | 4             |
| 20                    | Rolling over in bed.                                       | 0   | 1                         | 2                   | 3                          | 4             |
| <b>Column Totals:</b> |  |   |                           |                     |                            |               |

Minimum Level of Detectable Change (90% Confidence): 9 points

SCORE= Combined Column Total: \_\_\_\_/ 80 = \_\_\_\_

Please submit the sum of responses.

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