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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	EXTREME DIFFICULTY OR UNABLE TO PERFORM	QUITE A BIT OF DIFFICULTY	MODERATE DIFFICULTY	A LIT BIT OF DIFFICULTY	NO DIFFICULTY
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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