Name_____ Date_____ Patient#_____

Lower Extremity Functional Scale

Today, do you or would you have any difficulty with: (Mark one number on each line)

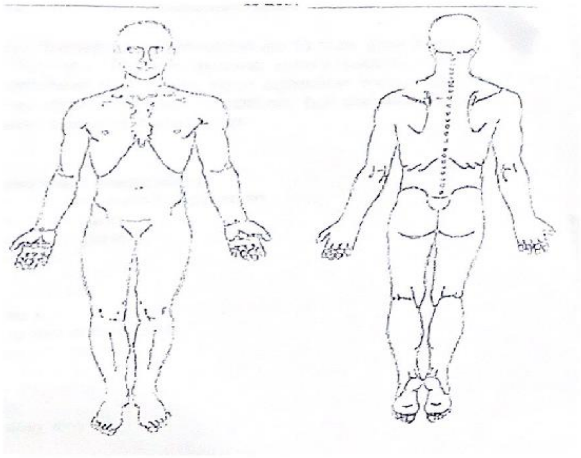
Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
a. Any of your usual work, household, or school activities	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
b. Your usual hobbies, recreational or sporting activities	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
c. Getting into or out of the bath	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
d. Walking between rooms	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
e. Putting on your shoes or socks	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
f. Squatting	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
g. Lifting an object, like a bag of groceries, from the floor	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
h. Performing light activities around your home	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
i. Performing heavy activities around your home	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
j. Getting into or out of your car	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
k. Walking 2 blocks	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
l. Walking a mile	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
m. Going up or down 10 stairs (about 1 flight)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
n. Standing for 1 hour	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
o. Sitting for 1hour	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
p. Running on even ground	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
q. Running on uneven ground	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
r. Making sharp turns while running fast	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
s. Hopping	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐
t. Rolling over in bed	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐

Pain and Symptom Status Report

Name_____ Date_____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness	Pins and Needles	Stabbing	Other
MMM	__ __ __ __	() () () () ()	NNNNN	/ / / / /	x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is:_____

Date First Symptom of your problem occurred on:_____

2nd Complaint: _____

3rd Complaint: _____

Please mark on scale below to indicate your <u>CURRENT</u> level of pain:
No pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Pain as bad as it gets
Please mark on scale below to indicate your <u>AVERAGE</u> level of pain:
No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Pain as bad as it gets
Please mark scale below to indicate your <u>WORST</u> level of pain:
No Pain ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 Pain as bad as it gets