

PATIENT NAME: _____ ID#: _____ DATE: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. **Please circle the answers below that best apply.**

LEFS – INITIAL VISIT

Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

| | Extreme Difficulty or 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, recreational 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 |

Source: Binkley et al (1999): *The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79:371-383.*

| Therapist Use Only | | |
|--------------------|---|--|
| Comorbidities: | <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Condition <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Multiple Treatment Areas | <input type="checkbox"/> Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) <input type="checkbox"/> Obesity <input type="checkbox"/> Surgery for this Problem <input type="checkbox"/> Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia) |
| | | ICD Code: _____ |