

Lower Extremity Functional Scale

Patient information: _____

Medical history (if needed)

Symptoms (if needed)

We want to know whether you are having difficulties performing the tasks listed below because of your lower limb issues. Please provide an answer for each activity based on how your lower limb feels today. Today, do you or would you have any difficulty at all with:

Any of your usual work, housework, or school activities

0
 1
 2
 3
 4

Your usual hobbies, recreational, or sporting activities

0
 1
 2
 3
 4

Getting into or out of the bath

0
 1
 2
 3
 4

Walking between rooms

0
 1
 2
 3
 4

Putting on shoes or socks

0
 1
 2
 3
 4

Squatting

0
 1
 2
 3
 4

Lifting an object like groceries or a bag

0
 1
 2
 3
 4

Doing light activities around the house

0
 1
 2
 3
 4

Performing heavy activities around the house

0
 1
 2
 3
 4

Getting into a car

0
 1
 2
 3
 4

Walking 2 blocks

0
 1
 2
 3
 4

Walking a mile

0 1 2 3 4

Going up and down 10 stairs (about a flight)

0 1 2 3 4

Standing for 1 hour

0 1 2 3 4

Sitting for 1 hour

0 1 2 3 4

Running on even ground

0 1 2 3 4

Running on uneven ground

0 1 2 3 4

Making sharp turns while running fast

0 1 2 3 4

Hopping

0 1 2 3 4

Rolling over in bed

0 1 2 3 4

Total score: _____

Additional notes